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: 15-1304	Period: From 01/01/2022 To 12/31/2022	Worksheet S Parts I-III Date/Time Prepared: 5/18/2023 12:26 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 5/18/2023 Time: 12:26 pm
2. [ ] Manually prepared cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no.

Contractor use only

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

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

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by RUSH MEMORIAL HOSPITAL (15-1304) 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	Brad Smith		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	Brad Smith			2
3	Signatory Title	CEO			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	19,812	15,083	0	36,647	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	-78	0		0	5.00
6.00	SWING BED - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		3,976		0	10.00
200.00	TOTAL	0	19,734	19,059	0	36,647	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: 15-1304 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-2 Part I | Date/Time Prepared: 5/18/2023 12:26 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1300 NORTH MAIN STREET	PO Box:			1.00
2.00	City: RUSHVILLE	State: IN	Zip Code: 46173-	County: RUSH	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	RUSH MEMORIAL HOSPITAL	151304	99915	1	08/01/2000	N	O	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	RUSH SWING BEDS	15Z304	99915		08/01/2000	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC	RMH HEALTHCARE ASSOC	158539	99915		06/12/2019	N	O	O	15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

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

		1.00	2.00	3.00	
	Inpatient PPS Information				
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N			22.00
22.01	Did this hospital receive interim UCPs, including supplemental UCPs, for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N		22.01
22.02	Is this a newly merged hospital that requires a final UCP to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	N	22.03
22.04	Did this hospital receive a geographic reclassification from urban to rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.				22.04
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	0			23.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1304 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-2 Part I | Date/Time Prepared: 5/18/2023 12:26 pm

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

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	2		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1304 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-2 Part I Date/Time Prepared: 5/18/2023 12:26 pm

		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.				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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1304	Period: From 01/01/2022 To 12/31/2022	Worksheet S-2 Part I Date/Time Prepared: 5/18/2023 12:26 pm

		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	N	98.06
	Rural Providers			
105.00	Does this hospital qualify as a CAH?	Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	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.	2			118.00

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	135,952	0	0	118.01

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1304	Period: From 01/01/2022 To 12/31/2022	Worksheet S-2 Part I Date/Time Prepared: 5/18/2023 12:26 pm

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

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

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

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

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

		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

		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	02/07/2023	Y	02/07/2023	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: 15-1304	Period: From 01/01/2022 To 12/31/2022	Worksheet S-2 Part II Date/Time Prepared: 5/18/2023 12:26 pm

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

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

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

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

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	LANDON	HACKETT	41.00
42.00	Enter the employer/company name of the cost report preparer.	BLUE & CO., LLC		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-713-7929	LHACKETT@BLUEANDCO.COM	43.00

		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: 15-1304 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-3 Part I | Date/Time Prepared: 5/18/2023 12:26 pm

	Component	Worksheet A Line No.	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	23	8,395	29,856.00	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)		23	8,395	29,856.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	2	730	1,728.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		25	9,125	31,584.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	88.00				0	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		25				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care	30.00	0	0		0	34.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1304 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-3 Part I | Date/Time Prepared: 5/18/2023 12:26 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	587	8	1,244			1.00
2.00	HMO and other (see instructions)	316	61				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	10	0	10			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	6			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	597	8	1,260			7.00
8.00	INTENSIVE CARE UNIT	11	0	72			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)	608	8	1,332	0.00	263.87	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	2,795	963	9,260	0.00	26.16	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	290.03	27.00
28.00	Observation Bed Days		16	606			28.00
29.00	Ambulance Trips	108					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care	0	0	0			34.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1304 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-3 Part I Date/Time Prepared: 5/18/2023 12:26 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	195	2	392	1.00
2.00	HMO and other (see instructions)			80	17		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	195	2	392	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0.00					26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care						34.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-1304 | Component CCN: 15-8539 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-8 | Date/Time Prepared: 5/18/2023 12:26 pm

RHC I | Cost

		1.00	
	Clinic Address and Identification		
1.00	Street	201 CONRAD HARCOURT WAY	1.00

		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County	RUSHVILLE	IN	46173	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			08:00	05:00	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	RUSH	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	05:00	08:00	05:00	08:00	05:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA	Provider CCN: 15-1304 Component CCN: 15-8539	Period: From 01/01/2022 To 12/31/2022	Worksheet S-8 Date/Time Prepared: 5/18/2023 12:26 pm
		RHC I	Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	08:00	05:00				11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-1304 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-10 | Date/Time Prepared: 5/18/2023 12:26 pm

Line	Description	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)	0.343912	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	1,597,176	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?		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	19,462,995	6.00
7.00	Medicaid cost (line 1 times line 6)	6,693,558	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)	5,096,382	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)	5,096,382	19.00

Line	Description	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)	35,479	72,506	107,985	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	12,202	72,506	84,708	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)	12,202	72,506	84,708	23.00

Line	Description	1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	3,893,024	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	341,480	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	525,355	27.01
28.00	Non-Medicare bad debt expense (see instructions)	3,367,669	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	1,342,057	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,426,765	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	6,523,147	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1304 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A | Date/Time Prepared: 5/18/2023 12:26 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		2,234,458	2,234,458	0	2,234,458	1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	512,417	6,334,189	6,846,606	16,346	6,862,952	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,139,497	4,088,404	7,227,901	-131,457	7,096,444	5.00
7.00	00700	OPERATION OF PLANT	441,040	982,102	1,423,142	41,080	1,464,222	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	115,113	115,113	0	115,113	8.00
9.00	00900	HOUSEKEEPING	637,939	245,249	883,188	41,080	924,268	9.00
10.00	01000	DIETARY	387,872	107,463	495,335	-316,000	179,335	10.00
11.00	01100	CAFETERIA	0	0	0	348,864	348,864	11.00
13.00	01300	NURSING ADMINISTRATION	156,985	6,010	162,995	0	162,995	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	128,896	96,103	224,999	-51,495	173,504	14.00
15.00	01500	PHARMACY	557,170	5,115,560	5,672,730	-4,940,354	732,376	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	274,033	167,077	441,110	0	441,110	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	2,039,411	82,056	2,121,467	-36,950	2,084,517	30.00
31.00	03100	INTENSIVE CARE UNIT	83,172	98,708	181,880	-164	181,716	31.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,290,898	1,061,808	2,352,706	-953,596	1,399,110	50.00
51.00	05100	RECOVERY ROOM	0	30,284	30,284	192,746	223,030	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,271,502	646,191	1,917,693	-73,336	1,844,357	54.00
54.01	05401	ONCOLOGY	367,580	226,010	593,590	-5,937	587,653	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
60.00	06000	LABORATORY	864,220	1,348,352	2,212,572	-237,172	1,975,400	60.00
65.00	06500	RESPIRATORY THERAPY	194,919	54,216	249,135	-2,016	247,119	65.00
66.00	06600	PHYSICAL THERAPY	293,639	8,117	301,756	36,389	338,145	66.00
67.00	06700	OCCUPATIONAL THERAPY	197,123	6,914	204,037	36,349	240,386	67.00
68.00	06800	SPEECH PATHOLOGY	125,244	2,445	127,689	-72,831	54,858	68.00
69.00	06900	ELECTROCARDIOLOGY	106,547	9,088	115,635	67,433	183,068	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	1,668,725	1,668,725	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	1,081,608	1,081,608	0	1,081,608	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	54,778	8,343	63,121	4,936,379	4,999,500	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	1,862,967	177,724	2,040,691	-90,420	1,950,271	88.00
90.00	09000	CLINIC	957,838	266,096	1,223,934	-218,236	1,005,698	90.00
90.01	09001	SURGICAL ASSOCIATES	59,109	552,759	611,868	11,264	623,132	90.01
90.02	09002	ORTHOPAEDICS	536,917	412,005	948,922	11,642	960,564	90.02
90.03	09003	RHEUMATOLOGY	435,596	5,008	440,604	12,141	452,745	90.03
90.04	09004	SPECIALTY CLINIC	948,693	284,483	1,233,176	-236,139	997,037	90.04
90.05	09005	PEDIATRICS	467,441	44,436	511,877	-19,588	492,289	90.05
90.06	09006	WOMEN'S HEALTH	271,463	7,018	278,481	0	278,481	90.06
90.07	09007	PAIN MANAGEMENT	599,227	145,473	744,700	11,718	756,418	90.07
90.08	09008	ONCOLOGY MD	0	0	0	0	0	90.08
91.00	09100	EMERGENCY	941,135	1,735,182	2,676,317	-46,189	2,630,128	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	308,940	32,272	341,212	-276	340,936	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
	SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	20,514,208	27,818,324	48,332,532	0	48,332,532	118.00
	NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	FOUNDATION	167,543	162	167,705	0	167,705	193.01
193.02	19302	OCCUPATIONAL MEDICINE	0	0	0	0	0	193.02
193.03	19303	GUEST MEALS	0	0	0	0	0	193.03
194.00	07950	NON REIMBURSABLE	0	0	0	0	0	194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	20,681,751	27,818,486	48,500,237	0	48,500,237	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1304 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A | Date/Time Prepared: 5/18/2023 12:26 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
	GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	-96,793	2,137,665	1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-596	6,862,356	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-2,141,224	4,955,220	5.00
7.00	00700	OPERATION OF PLANT	-1,485	1,462,737	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	115,113	8.00
9.00	00900	HOUSEKEEPING	0	924,268	9.00
10.00	01000	DIETARY	-2,674	176,661	10.00
11.00	01100	CAFETERIA	-78,279	270,585	11.00
13.00	01300	NURSING ADMINISTRATION	0	162,995	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	173,504	14.00
15.00	01500	PHARMACY	-119,560	612,816	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	441,110	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-1,076,542	1,007,975	30.00
31.00	03100	INTENSIVE CARE UNIT	-74,793	106,923	31.00
	ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-310,090	1,089,020	50.00
51.00	05100	RECOVERY ROOM	0	223,030	51.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-751,567	1,092,790	54.00
54.01	05401	ONCOLOGY	-189,300	398,353	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	55.00
60.00	06000	LABORATORY	-5,056	1,970,344	60.00
65.00	06500	RESPIRATORY THERAPY	0	247,119	65.00
66.00	06600	PHYSICAL THERAPY	0	338,145	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	240,386	67.00
68.00	06800	SPEECH PATHOLOGY	0	54,858	68.00
69.00	06900	ELECTROCARDIOLOGY	-229	182,839	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	-5,403	1,663,322	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	1,081,608	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-5,177	4,994,323	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	77.00
	OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	1,950,271	88.00
90.00	09000	CLINIC	-649,894	355,804	90.00
90.01	09001	SURGICAL ASSOCIATES	-560,181	62,951	90.01
90.02	09002	ORTHOPAEDICS	-952,482	8,082	90.02
90.03	09003	RHEUMATOLOGY	-492,328	-39,583	90.03
90.04	09004	SPECIALTY CLINIC	-935,119	61,918	90.04
90.05	09005	PEDIATRICS	-464,338	27,951	90.05
90.06	09006	WOMEN'S HEALTH	-291,254	-12,773	90.06
90.07	09007	PAIN MANAGEMENT	-711,735	44,683	90.07
90.08	09008	ONCOLOGY MD	0	0	90.08
91.00	09100	EMERGENCY	0	2,630,128	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
	OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	-740	340,196	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	102.00
	SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-9,916,839	38,415,693	118.00
	NONREIMBURSABLE COST CENTERS				
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	193.00
193.01	19301	FOUNDATION	0	167,705	193.01
193.02	19302	OCCUPATIONAL MEDICINE	0	0	193.02
193.03	19303	GUEST MEALS	0	0	193.03
194.00	07950	NON REIMBURSABLE	0	0	194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-9,916,839	38,583,398	200.00

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	B - DIETARY/ CAFETERIA				
1.00	CAFETERIA	11.00	273,178	75,686	1.00
	0		273,178	75,686	
	C - MED SUPPLY RECLASS				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	1,668,725	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
	0		0	1,668,725	
	D - DRUGS RECLASS				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	4,940,354	1.00
	TOTALS		0	4,940,354	
	E - SALARY RECLASS				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	16,432	0	1.00
2.00	OPERATION OF PLANT	7.00	41,080	0	2.00
3.00	HOUSEKEEPING	9.00	41,080	0	3.00
4.00	DIETARY	10.00	32,864	0	4.00
5.00	RECOVERY ROOM	51.00	203,461	0	5.00
6.00	PHYSICAL THERAPY	66.00	36,416	0	6.00
7.00	OCCUPATIONAL THERAPY	67.00	36,416	0	7.00
	0		407,749	0	
	G - PHYSICIAN PRACTICE ADMIN RECLASS				
1.00	CLINIC	90.00	8,446	0	1.00
2.00	SURGICAL ASSOCIATES	90.01	12,141	0	2.00
3.00	ORTHOPAEDICS	90.02	12,141	0	3.00
4.00	RHEUMATOLOGY	90.03	12,141	0	4.00
5.00	SPECIALTY CLINIC	90.04	24,282	0	5.00
6.00	PEDIATRICS	90.05	12,141	0	6.00
7.00	PAIN MANAGEMENT	90.07	12,141	0	7.00
	0		93,433	0	
	H - RECLASS RHC EXPENSE				
1.00	RURAL HEALTH CLINIC	88.00	22,896	0	1.00
	0		22,896	0	
	I - ECHO EXPENSE RECLASS				
1.00	ELECTROCARDIOLOGY	69.00	0	67,954	1.00
	0		0	67,954	
500.00	Grand Total: Increases		797,256	6,752,719	500.00

RECLASSIFICATIONS

Provider CCN: 15-1304 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-6 | Date/Time Prepared: 5/18/2023 12:26 pm

	Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	B - DIETARY/ CAFETERIA					
1.00	DIETARY	10.00	273,178	75,686	0	1.00
	0		273,178	75,686		
	C - MED SUPPLY RECLASS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	86	0	1.00
2.00	CENTRAL SERVICES & SUPPLY	14.00	0	51,495	0	2.00
3.00	ADULTS & PEDIATRICS	30.00	0	14,054	0	3.00
4.00	INTENSIVE CARE UNIT	31.00	0	164	0	4.00
5.00	OPERATING ROOM	50.00	0	750,135	0	5.00
6.00	RECOVERY ROOM	51.00	0	10,715	0	6.00
7.00	RADIOLOGY-DIAGNOSTIC	54.00	0	5,382	0	7.00
8.00	ONCOLOGY	54.01	0	5,937	0	8.00
9.00	LABORATORY	60.00	0	237,172	0	9.00
10.00	RESPIRATORY THERAPY	65.00	0	2,016	0	10.00
11.00	PHYSICAL THERAPY	66.00	0	27	0	11.00
12.00	OCCUPATIONAL THERAPY	67.00	0	67	0	12.00
13.00	ELECTROCARDIOLOGY	69.00	0	521	0	13.00
14.00	DRUGS CHARGED TO PATIENTS	73.00	0	3,975	0	14.00
15.00	RURAL HEALTH CLINIC	88.00	0	19,883	0	15.00
16.00	CLINIC	90.00	0	226,682	0	16.00
17.00	SURGICAL ASSOCIATES	90.01	0	877	0	17.00
18.00	ORTHOPAEDICS	90.02	0	499	0	18.00
19.00	SPECIALTY CLINIC	90.04	0	260,421	0	19.00
20.00	PEDIATRICS	90.05	0	31,729	0	20.00
21.00	PAIN MANAGEMENT	90.07	0	423	0	21.00
22.00	EMERGENCY	91.00	0	46,189	0	22.00
23.00	AMBULANCE SERVICES	95.00	0	276	0	23.00
	0		0	1,668,725		
	D - DRUGS RECLASS					
1.00	PHARMACY	15.00	0	4,940,354	0	1.00
	TOTALS		0	4,940,354		
	E - SALARY RECLASS					
1.00	ADMINISTRATIVE & GENERAL	5.00	131,457	0	0	1.00
2.00	OPERATING ROOM	50.00	203,461	0	0	2.00
3.00	SPEECH PATHOLOGY	68.00	72,831	0	0	3.00
4.00		0.00	0	0	0	4.00
5.00		0.00	0	0	0	5.00
6.00		0.00	0	0	0	6.00
7.00		0.00	0	0	0	7.00
	0		407,749	0		
	G - PHYSICIAN PRACTICE ADMIN RECLASS					
1.00	RURAL HEALTH CLINIC	88.00	93,433	0	0	1.00
2.00		0.00	0	0	0	2.00
3.00		0.00	0	0	0	3.00
4.00		0.00	0	0	0	4.00
5.00		0.00	0	0	0	5.00
6.00		0.00	0	0	0	6.00
7.00		0.00	0	0	0	7.00
	0		93,433	0		
	H - RECLASS RHC EXPENSE					
1.00	ADULTS & PEDIATRICS	30.00	22,896	0	0	1.00
	0		22,896	0		
	I - ECHO EXPENSE RECLASS					
1.00	RADIOLOGY-DIAGNOSTIC	54.00	0	67,954	0	1.00
	0		0	67,954		
500.00	Grand Total: Decreases		797,256	6,752,719		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1304 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-7 Part I Date/Time Prepared: 5/18/2023 12:26 pm

		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	188,708	402,555	0	402,555	0	1.00
2.00	Land Improvements	549,432	16,000	0	16,000	0	2.00
3.00	Buildings and Fixtures	22,099,164	3,926	0	3,926	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	2,841,893	233,148	0	233,148	0	5.00
6.00	Movable Equipment	19,639,114	957,811	0	957,811	329,325	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	45,318,311	1,613,440	0	1,613,440	329,325	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	45,318,311	1,613,440	0	1,613,440	329,325	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	591,263	0	1.00
2.00	Land Improvements	565,432	0	2.00
3.00	Buildings and Fixtures	22,103,090	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	3,075,041	0	5.00
6.00	Movable Equipment	20,267,600	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	46,602,426	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	46,602,426	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1304 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-7 Part II | Date/Time Prepared: 5/18/2023 12:26 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1,819,236	0	95,045	320,177	0	1.00
3.00	Total (sum of lines 1-2)	1,819,236	0	95,045	320,177	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	NEW CAP REL COSTS-BLDG & FIXT	0	2,234,458	1.00
3.00	Total (sum of lines 1-2)	0	2,234,458	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1304 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-7 Part III | Date/Time Prepared: 5/18/2023 12:26 pm

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	51,434,685	0	51,434,685	1.000000	0	1.00
3.00	Total (sum of lines 1-2)	51,434,685	0	51,434,685	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	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	1,817,333	0	1.00
3.00	Total (sum of lines 1-2)	0	0	0	1,817,333	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	NEW CAP REL COSTS-BLDG & FIXT	155	320,177	0	0	2,137,665	1.00
3.00	Total (sum of lines 1-2)	155	320,177	0	0	2,137,665	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1304 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-8 | Date/Time Prepared: 5/18/2023 12:26 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	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)		0		0.00	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	-7,290,556			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests		0		0.00	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
20.00	Vending machines		0		0.00	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 - NEW CAP REL COSTS-BLDG & FIXT		0	NEW 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	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1304 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-8 | Date/Time Prepared: 5/18/2023 12:26 pm

	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	
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	A	-1,903	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	32.00
33.00	CAFETERIA	B	-78,279	CAFETERIA	11.00	0	33.00
33.01	SALE OF DRUGS	B	-5,177	DRUGS CHARGED TO PATIENTS	73.00	0	33.01
33.02	SALE OF PODIATRY SUPPLIES	B	-5,403	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	33.02
33.03	PHYSICIAN APPLICATION FEES	B	-750	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04	NSF FEES	B	-596	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.04
33.05	COPIER FEES	B	-7,655	ADMINISTRATIVE & GENERAL	5.00	0	33.05
33.06	ATHLETIC TRAINER - SCHOOL REV	B	-9,025	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07	OCCUPATIONAL HEALTH	B	-102,125	CLINIC	90.00	0	33.07
33.08	SHUTTLE BUS SERVICES	B	-740	AMBULANCE SERVICES	95.00	0	33.08
33.09	MISC. INCOME	B	-300	ADMINISTRATIVE & GENERAL	5.00	0	33.09
33.10	MISC. INCOME	B	-49,476	RHEUMATOLOGY	90.03	0	33.10
33.11	INTEREST INCOME	B	-94,890	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	33.11
33.12	TELEPHONE SALARY	A	-6,182	ADMINISTRATIVE & GENERAL	5.00	0	33.12
33.13	TELEPHONE OTHER	A	-1,396	ADMINISTRATIVE & GENERAL	5.00	0	33.13
33.14	TELEPHONE BENEFITS	A	-981	ADMINISTRATIVE & GENERAL	5.00	0	33.14
33.15	ADVERTISING	A	-209,395	ADMINISTRATIVE & GENERAL	5.00	0	33.15
33.16	IHA & AHA LOBBYING	A	-4,722	ADMINISTRATIVE & GENERAL	5.00	0	33.16
33.17	REBATES	B	-5,292	ADMINISTRATIVE & GENERAL	5.00	0	33.17
33.18	REBATES	B	-1,485	OPERATION OF PLANT	7.00	0	33.18
33.19	REBATES	B	-2,674	DIETARY	10.00	0	33.19
33.20	REBATES	B	-119,560	PHARMACY	15.00	0	33.20
33.21	REBATES	B	-6,248	ADULTS & PEDIATRICS	30.00	0	33.21
33.22	REBATES	B	-9,636	OPERATING ROOM	50.00	0	33.22
33.23	REBATES	B	-1,582	RADIOLOGY-DIAGNOSTIC	54.00	0	33.23
33.24	REBATES	B	-5,056	LABORATORY	60.00	0	33.24
33.25	REBATES	B	-229	ELECTROCARDIOLOGY	69.00	0	33.25
33.26	HAF EXPENSE	B	-1,872,526	ADMINISTRATIVE & GENERAL	5.00	0	33.26
33.27	PHYSICIAN RECRUITMENTS	A	-23,000	ADMINISTRATIVE & GENERAL	5.00	0	33.27
33.28	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.28
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-9,916,839				50.00

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-1304 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-8-2 | Date/Time Prepared: 5/18/2023 12:26 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	1,070,294	1,070,294	0	0	0	1.00
2.00	31.00	INTENSIVE CARE UNIT	74,793	74,793	0	0	0	2.00
3.00	50.00	OPERATING ROOM	387,619	300,454	87,165	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	749,985	749,985	0	0	0	4.00
5.00	54.01	ONCOLOGY	189,300	189,300	0	0	0	5.00
6.00	60.00	LABORATORY	59,470	0	59,470	0	0	6.00
7.00	90.00	CLINIC	548,441	547,769	672	0	0	7.00
8.00	90.01	SURGICAL ASSOCIATES	564,985	560,181	4,804	0	0	8.00
9.00	90.02	ORTHOPAEDICS	958,159	952,482	5,677	0	0	9.00
10.00	90.03	RHEUMATOLOGY	444,986	442,852	2,134	0	0	10.00
11.00	90.04	SPECIALTY CLINIC	938,264	935,119	3,145	0	0	11.00
12.00	90.05	PEDIATRICS	464,359	464,338	21	0	0	12.00
13.00	90.06	WOMEN'S HEALTH	291,254	291,254	0	0	0	13.00
14.00	90.07	PAIN MANAGEMENT	711,756	711,735	21	0	0	14.00
15.00	91.00	EMERGENCY	1,564,836	0	1,564,836	0	0	15.00
200.00			9,018,501	7,290,556	1,727,945		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	31.00	INTENSIVE CARE UNIT	0	0	0	0	0	2.00
3.00	50.00	OPERATING ROOM	0	0	0	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	4.00
5.00	54.01	ONCOLOGY	0	0	0	0	0	5.00
6.00	60.00	LABORATORY	0	0	0	0	0	6.00
7.00	90.00	CLINIC	0	0	0	0	0	7.00
8.00	90.01	SURGICAL ASSOCIATES	0	0	0	0	0	8.00
9.00	90.02	ORTHOPAEDICS	0	0	0	0	0	9.00
10.00	90.03	RHEUMATOLOGY	0	0	0	0	0	10.00
11.00	90.04	SPECIALTY CLINIC	0	0	0	0	0	11.00
12.00	90.05	PEDIATRICS	0	0	0	0	0	12.00
13.00	90.06	WOMEN'S HEALTH	0	0	0	0	0	13.00
14.00	90.07	PAIN MANAGEMENT	0	0	0	0	0	14.00
15.00	91.00	EMERGENCY	0	0	0	0	0	15.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	1.00	2.00	15.00	16.00	17.00	18.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	1,070,294	1.00
2.00	31.00	INTENSIVE CARE UNIT	0	0	0	74,793	2.00
3.00	50.00	OPERATING ROOM	0	0	0	300,454	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	749,985	4.00
5.00	54.01	ONCOLOGY	0	0	0	189,300	5.00
6.00	60.00	LABORATORY	0	0	0	0	6.00
7.00	90.00	CLINIC	0	0	0	547,769	7.00
8.00	90.01	SURGICAL ASSOCIATES	0	0	0	560,181	8.00
9.00	90.02	ORTHOPAEDICS	0	0	0	952,482	9.00
10.00	90.03	RHEUMATOLOGY	0	0	0	442,852	10.00
11.00	90.04	SPECIALTY CLINIC	0	0	0	935,119	11.00
12.00	90.05	PEDIATRICS	0	0	0	464,338	12.00
13.00	90.06	WOMEN'S HEALTH	0	0	0	291,254	13.00
14.00	90.07	PAIN MANAGEMENT	0	0	0	711,735	14.00
15.00	91.00	EMERGENCY	0	0	0	0	15.00
200.00			0	0	0	7,290,556	200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1304 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part I Date/Time Prepared: 5/18/2023 12:26 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS NEW BLDG & FIXT	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
			0	1.00	4.00	4A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	2,137,665	2,137,665				1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	6,862,356	78,006	6,940,362			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,955,220	171,860	1,035,930	6,163,010	6,163,010	5.00
7.00	00700	OPERATION OF PLANT	1,462,737	307,943	166,035	1,936,715	368,164	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	115,113	0	0	115,113	21,883	8.00
9.00	00900	HOUSEKEEPING	924,268	61,428	233,844	1,219,540	231,831	9.00
10.00	01000	DIETARY	176,661	72,131	50,817	299,609	56,955	10.00
11.00	01100	CAFETERIA	270,585	17,308	94,078	381,971	72,612	11.00
13.00	01300	NURSING ADMINISTRATION	162,995	2,283	54,063	219,341	41,696	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	173,504	45,524	44,390	263,418	50,075	14.00
15.00	01500	PHARMACY	612,816	34,016	191,881	838,713	159,437	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	441,110	77,519	94,373	613,002	116,530	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,007,975	127,945	694,458	1,830,378	347,949	30.00
31.00	03100	INTENSIVE CARE UNIT	106,923	26,382	28,643	161,948	30,786	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,089,020	127,852	374,497	1,591,369	302,514	50.00
51.00	05100	RECOVERY ROOM	223,030	11,021	70,069	304,120	57,812	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,092,790	79,072	437,886	1,609,748	306,008	54.00
54.01	05401	ONCOLOGY	398,353	72,692	126,589	597,634	113,608	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
60.00	06000	LABORATORY	1,970,344	52,596	297,624	2,320,564	441,132	60.00
65.00	06500	RESPIRATORY THERAPY	247,119	2,620	67,127	316,866	60,235	65.00
66.00	06600	PHYSICAL THERAPY	338,145	36,973	113,666	488,784	92,916	66.00
67.00	06700	OCCUPATIONAL THERAPY	240,386	16,148	80,427	336,961	64,055	67.00
68.00	06800	SPEECH PATHOLOGY	54,858	3,387	18,050	76,295	14,503	68.00
69.00	06900	ELECTROCARDIOLOGY	182,839	16,765	36,693	236,297	44,919	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,663,322	0	0	1,663,322	316,193	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,081,608	0	0	1,081,608	205,610	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,994,323	6,118	18,865	5,019,306	954,148	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,950,271	121,677	617,286	2,689,234	511,215	88.00
90.00	09000	CLINIC	355,804	180,354	332,774	868,932	165,181	90.00
90.01	09001	SURGICAL ASSOCIATES	62,951	30,985	24,537	118,473	22,521	90.01
90.02	09002	ORTHOPAEDICS	8,082	19,272	189,087	216,441	41,145	90.02
90.03	09003	RHEUMATOLOGY	-39,583	42,399	154,194	157,010	29,847	90.03
90.04	09004	SPECIALTY CLINIC	61,918	59,632	335,078	456,628	86,804	90.04
90.05	09005	PEDIATRICS	27,951	62,850	165,161	255,962	48,658	90.05
90.06	09006	WOMEN'S HEALTH	-12,773	0	93,488	80,715	15,344	90.06
90.07	09007	PAIN MANAGEMENT	44,683	28,796	210,546	284,025	53,992	90.07
90.08	09008	ONCOLOGY MD	0	0	0	0	0	90.08
91.00	09100	EMERGENCY	2,630,128	74,844	324,113	3,029,085	575,820	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	340,196	33,436	106,394	480,026	91,252	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	38,415,693	2,101,834	6,882,663	38,322,163	6,113,350	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	FOUNDATION	167,705	35,831	57,699	261,235	49,660	193.01
193.02	19302	OCCUPATIONAL MEDICINE	0	0	0	0	0	193.02
193.03	19303	GUEST MEALS	0	0	0	0	0	193.03
194.00	07950	NON REIMBURSABLE	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	38,583,398	2,137,665	6,940,362	38,583,398	6,163,010	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1304 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part I | Date/Time Prepared: 5/18/2023 12:26 pm

		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	NEW 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	2,304,879					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	136,996				8.00
9.00	00900	HOUSEKEEPING	89,618	9,615	1,550,604			9.00
10.00	01000	DIETARY	105,233	3,942	73,659	539,398		10.00
11.00	01100	CAFETERIA	25,250	0	17,674	0	497,507	11.00
13.00	01300	NURSING ADMINISTRATION	3,330	0	2,331	0	2,524	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	66,415	0	46,488	0	8,820	14.00
15.00	01500	PHARMACY	49,627	0	34,737	0	15,042	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	113,094	0	79,162	0	17,715	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	186,661	82,185	130,656	509,887	53,571	30.00
31.00	03100	INTENSIVE CARE UNIT	38,490	7,144	26,941	29,511	2,449	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	186,525	8,966	130,561	0	41,228	50.00
51.00	05100	RECOVERY ROOM	16,078	0	11,254	0	2,324	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	115,360	5,793	80,748	0	34,356	54.00
54.01	05401	ONCOLOGY	106,051	0	74,232	0	15,841	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
60.00	06000	LABORATORY	76,734	0	53,711	0	37,430	60.00
65.00	06500	RESPIRATORY THERAPY	3,822	1,154	2,675	0	7,521	65.00
66.00	06600	PHYSICAL THERAPY	53,940	2,697	37,756	0	11,969	66.00
67.00	06700	OCCUPATIONAL THERAPY	23,558	1,240	16,490	0	6,771	67.00
68.00	06800	SPEECH PATHOLOGY	4,941	53	3,458	0	3,348	68.00
69.00	06900	ELECTROCARDIOLOGY	24,459	0	17,120	0	5,047	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,926	0	6,248	0	2,399	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	177,517	0	124,255	0	67,114	88.00
90.00	09000	CLINIC	263,122	0	184,179	0	40,628	90.00
90.01	09001	SURGICAL ASSOCIATES	45,205	0	31,642	0	4,548	90.01
90.02	09002	ORTHOPAEDICS	28,117	0	19,681	0	7,021	90.02
90.03	09003	RHEUMATOLOGY	61,857	0	43,297	0	7,521	90.03
90.04	09004	SPECIALTY CLINIC	86,998	0	60,895	0	25,561	90.04
90.05	09005	PEDIATRICS	91,693	0	64,182	0	12,643	90.05
90.06	09006	WOMEN'S HEALTH	0	0	0	0	0	90.06
90.07	09007	PAIN MANAGEMENT	42,011	0	29,406	0	10,170	90.07
90.08	09008	ONCOLOGY MD	0	0	0	0	0	90.08
91.00	09100	EMERGENCY	109,191	14,207	76,430	0	33,882	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	48,781	0	34,145	0	14,542	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,252,604	136,996	1,514,013	539,398	491,985	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	FOUNDATION	52,275	0	36,591	0	5,522	193.01
193.02	19302	OCCUPATIONAL MEDICINE	0	0	0	0	0	193.02
193.03	19303	GUEST MEALS	0	0	0	0	0	193.03
194.00	07950	NON REIMBURSABLE	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	2,304,879	136,996	1,550,604	539,398	497,507	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1304 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part I | Date/Time Prepared: 5/18/2023 12:26 pm

		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	NEW 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	269,222					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	435,216				14.00
15.00	01500	PHARMACY	0	2,009	1,099,565			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	98	0	939,601		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	52,890	4,053	0	101,854	3,300,084	30.00
31.00	03100	INTENSIVE CARE UNIT	2,429	123	0	3,446	303,267	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	40,702	99,314	0	0	2,401,179	50.00
51.00	05100	RECOVERY ROOM	2,305	2,177	0	43,566	439,636	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	33,920	5,736	0	633,516	2,825,185	54.00
54.01	05401	ONCOLOGY	15,633	1,890	0	0	924,889	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
60.00	06000	LABORATORY	36,951	70,473	0	0	3,036,995	60.00
65.00	06500	RESPIRATORY THERAPY	7,438	1,176	0	12,188	413,075	65.00
66.00	06600	PHYSICAL THERAPY	11,810	437	0	0	700,309	66.00
67.00	06700	OCCUPATIONAL THERAPY	6,676	418	0	0	456,169	67.00
68.00	06800	SPEECH PATHOLOGY	3,311	113	0	0	106,022	68.00
69.00	06900	ELECTROCARDIOLOGY	4,973	1,204	0	0	334,019	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	103,828	0	0	2,083,343	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	122,290	0	0	1,409,508	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,376	437	1,099,565	0	7,093,405	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	3,447	0	0	3,572,782	88.00
90.00	09000	CLINIC	0	2,743	0	0	1,524,785	90.00
90.01	09001	SURGICAL ASSOCIATES	0	143	0	0	222,532	90.01
90.02	09002	ORTHOPAEDICS	0	108	0	0	312,513	90.02
90.03	09003	RHEUMATOLOGY	0	60	0	0	299,592	90.03
90.04	09004	SPECIALTY CLINIC	0	2,021	0	0	718,907	90.04
90.05	09005	PEDIATRICS	0	638	0	0	473,776	90.05
90.06	09006	WOMEN'S HEALTH	0	0	0	0	96,059	90.06
90.07	09007	PAIN MANAGEMENT	0	555	0	0	420,159	90.07
90.08	09008	ONCOLOGY MD	0	0	0	0	0	90.08
91.00	09100	EMERGENCY	33,450	9,265	0	145,031	4,026,361	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	14,358	460	0	0	683,564	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	269,222	435,216	1,099,565	939,601	38,178,115	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	FOUNDATION	0	0	0	0	405,283	193.01
193.02	19302	OCCUPATIONAL MEDICINE	0	0	0	0	0	193.02
193.03	19303	GUEST MEALS	0	0	0	0	0	193.03
194.00	07950	NON REIMBURSABLE	0	0	0	0	0	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)	269,222	435,216	1,099,565	939,601	38,583,398	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1304 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part I | Date/Time Prepared: 5/18/2023 12:26 pm

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			25.00	26.00	
	GENERAL SERVICE COST CENTERS				
1.00	00100	NEW 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	3,300,084	30.00
31.00	03100	INTENSIVE CARE UNIT	0	303,267	31.00
	ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	2,401,179	50.00
51.00	05100	RECOVERY ROOM	0	439,636	51.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,825,185	54.00
54.01	05401	ONCOLOGY	0	924,889	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	55.00
60.00	06000	LABORATORY	0	3,036,995	60.00
65.00	06500	RESPIRATORY THERAPY	0	413,075	65.00
66.00	06600	PHYSICAL THERAPY	0	700,309	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	456,169	67.00
68.00	06800	SPEECH PATHOLOGY	0	106,022	68.00
69.00	06900	ELECTROCARDIOLOGY	0	334,019	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,083,343	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	1,409,508	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	7,093,405	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	77.00
	OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	3,572,782	88.00
90.00	09000	CLINIC	0	1,524,785	90.00
90.01	09001	SURGICAL ASSOCIATES	0	222,532	90.01
90.02	09002	ORTHOPAEDICS	0	312,513	90.02
90.03	09003	RHEUMATOLOGY	0	299,592	90.03
90.04	09004	SPECIALTY CLINIC	0	718,907	90.04
90.05	09005	PEDIATRICS	0	473,776	90.05
90.06	09006	WOMEN'S HEALTH	0	96,059	90.06
90.07	09007	PAIN MANAGEMENT	0	420,159	90.07
90.08	09008	ONCOLOGY MD	0	0	90.08
91.00	09100	EMERGENCY	0	4,026,361	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		92.00
	OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	683,564	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	102.00
	SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	38,178,115	118.00
	NONREIMBURSABLE COST CENTERS				
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	193.00
193.01	19301	FOUNDATION	0	405,283	193.01
193.02	19302	OCCUPATIONAL MEDICINE	0	0	193.02
193.03	19303	GUEST MEALS	0	0	193.03
194.00	07950	NON REIMBURSABLE	0	0	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	38,583,398	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1304 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part II | Date/Time Prepared: 5/18/2023 12:26 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	
			0	1.00	2A	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	78,006	78,006	78,006		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	171,860	171,860	11,640	183,500	5.00
7.00	00700	OPERATION OF PLANT	0	307,943	307,943	1,866	10,962	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	652	8.00
9.00	00900	HOUSEKEEPING	0	61,428	61,428	2,628	6,903	9.00
10.00	01000	DIETARY	0	72,131	72,131	571	1,696	10.00
11.00	01100	CAFETERIA	0	17,308	17,308	1,057	2,162	11.00
13.00	01300	NURSING ADMINISTRATION	0	2,283	2,283	608	1,241	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	45,524	45,524	499	1,491	14.00
15.00	01500	PHARMACY	0	34,016	34,016	2,157	4,747	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	77,519	77,519	1,061	3,470	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	127,945	127,945	7,806	10,360	30.00
31.00	03100	INTENSIVE CARE UNIT	0	26,382	26,382	322	917	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	127,852	127,852	4,209	9,007	50.00
51.00	05100	RECOVERY ROOM	0	11,021	11,021	788	1,721	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	79,072	79,072	4,922	9,111	54.00
54.01	05401	ONCOLOGY	0	72,692	72,692	1,423	3,383	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
60.00	06000	LABORATORY	0	52,596	52,596	3,345	13,134	60.00
65.00	06500	RESPIRATORY THERAPY	0	2,620	2,620	755	1,793	65.00
66.00	06600	PHYSICAL THERAPY	0	36,973	36,973	1,278	2,767	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	16,148	16,148	904	1,907	67.00
68.00	06800	SPEECH PATHOLOGY	0	3,387	3,387	203	432	68.00
69.00	06900	ELECTROCARDIOLOGY	0	16,765	16,765	412	1,337	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	9,414	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	6,122	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	6,118	6,118	212	28,407	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	121,677	121,677	6,938	15,221	88.00
90.00	09000	CLINIC	0	180,354	180,354	3,740	4,918	90.00
90.01	09001	SURGICAL ASSOCIATES	0	30,985	30,985	276	671	90.01
90.02	09002	ORTHOPAEDICS	0	19,272	19,272	2,125	1,225	90.02
90.03	09003	RHEUMATOLOGY	0	42,399	42,399	1,733	889	90.03
90.04	09004	SPECIALTY CLINIC	0	59,632	59,632	3,766	2,585	90.04
90.05	09005	PEDIATRICS	0	62,850	62,850	1,856	1,449	90.05
90.06	09006	WOMEN'S HEALTH	0	0	0	1,051	457	90.06
90.07	09007	PAIN MANAGEMENT	0	28,796	28,796	2,367	1,608	90.07
90.08	09008	ONCOLOGY MD	0	0	0	0	0	90.08
91.00	09100	EMERGENCY	0	74,844	74,844	3,643	17,145	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	33,436	33,436	1,196	2,717	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	2,101,834	2,101,834	77,357	182,021	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	FOUNDATION	0	35,831	35,831	649	1,479	193.01
193.02	19302	OCCUPATIONAL MEDICINE	0	0	0	0	0	193.02
193.03	19303	GUEST MEALS	0	0	0	0	0	193.03
194.00	07950	NON REIMBURSABLE	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments			0			200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	2,137,665	2,137,665	78,006	183,500	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1304 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part II | Date/Time Prepared: 5/18/2023 12:26 pm

		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	NEW 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	320,771					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	652				8.00
9.00	00900	HOUSEKEEPING	12,472	46	83,477			9.00
10.00	01000	DIETARY	14,645	19	3,965	93,027		10.00
11.00	01100	CAFETERIA	3,514	0	952	0	24,993	11.00
13.00	01300	NURSING ADMINISTRATION	463	0	125	0	127	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	9,243	0	2,503	0	443	14.00
15.00	01500	PHARMACY	6,907	0	1,870	0	756	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	15,739	0	4,262	0	890	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	25,978	390	7,034	87,937	2,691	30.00
31.00	03100	INTENSIVE CARE UNIT	5,357	34	1,450	5,090	123	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	25,959	43	7,029	0	2,071	50.00
51.00	05100	RECOVERY ROOM	2,238	0	606	0	117	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	16,055	28	4,347	0	1,726	54.00
54.01	05401	ONCOLOGY	14,759	0	3,996	0	796	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
60.00	06000	LABORATORY	10,679	0	2,892	0	1,880	60.00
65.00	06500	RESPIRATORY THERAPY	532	5	144	0	378	65.00
66.00	06600	PHYSICAL THERAPY	7,507	13	2,033	0	601	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,279	6	888	0	340	67.00
68.00	06800	SPEECH PATHOLOGY	688	0	186	0	168	68.00
69.00	06900	ELECTROCARDIOLOGY	3,404	0	922	0	254	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,242	0	336	0	121	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	24,705	0	6,689	0	3,371	88.00
90.00	09000	CLINIC	36,617	0	9,915	0	2,041	90.00
90.01	09001	SURGICAL ASSOCIATES	6,291	0	1,703	0	228	90.01
90.02	09002	ORTHOPAEDICS	3,913	0	1,060	0	353	90.02
90.03	09003	RHEUMATOLOGY	8,609	0	2,331	0	378	90.03
90.04	09004	SPECIALTY CLINIC	12,108	0	3,278	0	1,284	90.04
90.05	09005	PEDIATRICS	12,761	0	3,455	0	635	90.05
90.06	09006	WOMEN'S HEALTH	0	0	0	0	0	90.06
90.07	09007	PAIN MANAGEMENT	5,847	0	1,583	0	511	90.07
90.08	09008	ONCOLOGY MD	0	0	0	0	0	90.08
91.00	09100	EMERGENCY	15,196	68	4,115	0	1,702	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	6,789	0	1,838	0	731	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	313,496	652	81,507	93,027	24,716	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	FOUNDATION	7,275	0	1,970	0	277	193.01
193.02	19302	OCCUPATIONAL MEDICINE	0	0	0	0	0	193.02
193.03	19303	GUEST MEALS	0	0	0	0	0	193.03
194.00	07950	NON REIMBURSABLE	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	320,771	652	83,477	93,027	24,993	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1304 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part II | Date/Time Prepared: 5/18/2023 12:26 pm

		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	NEW 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	4,847					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	59,703				14.00
15.00	01500	PHARMACY	0	276	50,729			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	13	0	102,954		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	952	556	0	11,160	282,809	30.00
31.00	03100	INTENSIVE CARE UNIT	44	17	0	378	40,114	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	733	13,624	0	0	190,527	50.00
51.00	05100	RECOVERY ROOM	41	299	0	4,774	21,605	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	611	787	0	69,416	186,075	54.00
54.01	05401	ONCOLOGY	281	259	0	0	97,589	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
60.00	06000	LABORATORY	665	9,668	0	0	94,859	60.00
65.00	06500	RESPIRATORY THERAPY	134	161	0	1,335	7,857	65.00
66.00	06600	PHYSICAL THERAPY	213	60	0	0	51,445	66.00
67.00	06700	OCCUPATIONAL THERAPY	120	57	0	0	23,649	67.00
68.00	06800	SPEECH PATHOLOGY	60	16	0	0	5,140	68.00
69.00	06900	ELECTROCARDIOLOGY	90	165	0	0	23,349	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	14,243	0	0	23,657	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	16,775	0	0	22,897	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	43	60	50,729	0	87,268	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	473	0	0	179,074	88.00
90.00	09000	CLINIC	0	376	0	0	237,961	90.00
90.01	09001	SURGICAL ASSOCIATES	0	20	0	0	40,174	90.01
90.02	09002	ORTHOPAEDICS	0	15	0	0	27,963	90.02
90.03	09003	RHEUMATOLOGY	0	8	0	0	56,347	90.03
90.04	09004	SPECIALTY CLINIC	0	277	0	0	82,930	90.04
90.05	09005	PEDIATRICS	0	88	0	0	83,094	90.05
90.06	09006	WOMEN'S HEALTH	0	0	0	0	1,508	90.06
90.07	09007	PAIN MANAGEMENT	0	76	0	0	40,788	90.07
90.08	09008	ONCOLOGY MD	0	0	0	0	0	90.08
91.00	09100	EMERGENCY	602	1,271	0	15,891	134,477	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	258	63	0	0	47,028	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	4,847	59,703	50,729	102,954	2,090,184	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	FOUNDATION	0	0	0	0	47,481	193.01
193.02	19302	OCCUPATIONAL MEDICINE	0	0	0	0	0	193.02
193.03	19303	GUEST MEALS	0	0	0	0	0	193.03
194.00	07950	NON REIMBURSABLE	0	0	0	0	0	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)	4,847	59,703	50,729	102,954	2,137,665	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1304 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part II | Date/Time Prepared: 5/18/2023 12:26 pm

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			25.00	26.00	
		GENERAL SERVICE COST CENTERS			
1.00	00100	NEW 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	282,809	30.00
31.00	03100	INTENSIVE CARE UNIT	0	40,114	31.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	190,527	50.00
51.00	05100	RECOVERY ROOM	0	21,605	51.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	186,075	54.00
54.01	05401	ONCOLOGY	0	97,589	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	55.00
60.00	06000	LABORATORY	0	94,859	60.00
65.00	06500	RESPIRATORY THERAPY	0	7,857	65.00
66.00	06600	PHYSICAL THERAPY	0	51,445	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	23,649	67.00
68.00	06800	SPEECH PATHOLOGY	0	5,140	68.00
69.00	06900	ELECTROCARDIOLOGY	0	23,349	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	23,657	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	22,897	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	87,268	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0	179,074	88.00
90.00	09000	CLINIC	0	237,961	90.00
90.01	09001	SURGICAL ASSOCIATES	0	40,174	90.01
90.02	09002	ORTHOPAEDICS	0	27,963	90.02
90.03	09003	RHEUMATOLOGY	0	56,347	90.03
90.04	09004	SPECIALTY CLINIC	0	82,930	90.04
90.05	09005	PEDIATRICS	0	83,094	90.05
90.06	09006	WOMEN'S HEALTH	0	1,508	90.06
90.07	09007	PAIN MANAGEMENT	0	40,788	90.07
90.08	09008	ONCOLOGY MD	0	0	90.08
91.00	09100	EMERGENCY	0	134,477	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0	47,028	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	102.00
		SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	2,090,184	118.00
		NONREIMBURSABLE COST CENTERS			
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	193.00
193.01	19301	FOUNDATION	0	47,481	193.01
193.02	19302	OCCUPATIONAL MEDICINE	0	0	193.02
193.03	19303	GUEST MEALS	0	0	193.03
194.00	07950	NON REIMBURSABLE	0	0	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	2,137,665	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1304 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B-1 | Date/Time Prepared: 5/18/2023 12:26 pm

		Cost Center Description	CAPITAL RELATED COSTS NEW 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	NEW CAP REL COSTS-BLDG & FIXT	114,247					1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4,169	20,152,902				4.00
5.00	00500	ADMINISTRATIVE & GENERAL	9,185	3,008,040	-6,163,010	32,420,388		5.00
7.00	00700	OPERATION OF PLANT	16,458	482,120	0	1,936,715	84,435	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	115,113	0	8.00
9.00	00900	HOUSEKEEPING	3,283	679,019	0	1,219,540	3,283	9.00
10.00	01000	DIETARY	3,855	147,558	0	299,609	3,855	10.00
11.00	01100	CAFETERIA	925	273,178	0	381,971	925	11.00
13.00	01300	NURSING ADMINISTRATION	122	156,985	0	219,341	122	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,433	128,896	0	263,418	2,433	14.00
15.00	01500	PHARMACY	1,818	557,170	0	838,713	1,818	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,143	274,033	0	613,002	4,143	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,838	2,016,515	0	1,830,378	6,838	30.00
31.00	03100	INTENSIVE CARE UNIT	1,410	83,172	0	161,948	1,410	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,833	1,087,437	0	1,591,369	6,833	50.00
51.00	05100	RECOVERY ROOM	589	203,461	0	304,120	589	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,226	1,271,502	0	1,609,748	4,226	54.00
54.01	05401	ONCOLOGY	3,885	367,580	0	597,634	3,885	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
60.00	06000	LABORATORY	2,811	864,220	0	2,320,564	2,811	60.00
65.00	06500	RESPIRATORY THERAPY	140	194,919	0	316,866	140	65.00
66.00	06600	PHYSICAL THERAPY	1,976	330,055	0	488,784	1,976	66.00
67.00	06700	OCCUPATIONAL THERAPY	863	233,539	0	336,961	863	67.00
68.00	06800	SPEECH PATHOLOGY	181	52,413	0	76,295	181	68.00
69.00	06900	ELECTROCARDIOLOGY	896	106,547	0	236,297	896	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	1,663,322	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	1,081,608	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	327	54,778	0	5,019,306	327	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	6,503	1,792,430	0	2,689,234	6,503	88.00
90.00	09000	CLINIC	9,639	966,284	0	868,932	9,639	90.00
90.01	09001	SURGICAL ASSOCIATES	1,656	71,250	0	118,473	1,656	90.01
90.02	09002	ORTHOPAEDICS	1,030	549,058	0	216,441	1,030	90.02
90.03	09003	RHEUMATOLOGY	2,266	447,737	0	157,010	2,266	90.03
90.04	09004	SPECIALTY CLINIC	3,187	972,975	0	456,628	3,187	90.04
90.05	09005	PEDIATRICS	3,359	479,582	0	255,962	3,359	90.05
90.06	09006	WOMEN'S HEALTH	0	271,463	0	80,715	0	90.06
90.07	09007	PAIN MANAGEMENT	1,539	611,368	0	284,025	1,539	90.07
90.08	09008	ONCOLOGY MD	0	0	0	0	0	90.08
91.00	09100	EMERGENCY	4,000	941,135	0	3,029,085	4,000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,787	308,940	0	480,026	1,787	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	112,332	19,985,359	-6,163,010	32,159,153	82,520	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	FOUNDATION	1,915	167,543	0	261,235	1,915	193.01
193.02	19302	OCCUPATIONAL MEDICINE	0	0	0	0	0	193.02
193.03	19303	GUEST MEALS	0	0	0	0	0	193.03
194.00	07950	NON REIMBURSABLE	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,137,665	6,940,362		6,163,010	2,304,879	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	18.710907	0.344385		0.190097	27.297673	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		78,006		183,500	320,771	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.003871		0.005660	3.799029	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1304 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B-1 | Date/Time Prepared: 5/18/2023 12:26 pm

		Cost Center Description	CAPITAL RELATED COSTS NEW 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	
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: 15-1304 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B-1 | Date/Time Prepared: 5/18/2023 12:26 pm

		Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	
			8.00	9.00	10.00	11.00	13.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW 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	28,495					8.00
9.00	00900	HOUSEKEEPING	2,000	81,152				9.00
10.00	01000	DIETARY	820	3,855	3,948			10.00
11.00	01100	CAFETERIA	0	925	0	19,911		11.00
13.00	01300	NURSING ADMINISTRATION	0	122	0	101	226,957	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	2,433	0	353	0	14.00
15.00	01500	PHARMACY	0	1,818	0	602	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	4,143	0	709	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	17,094	6,838	3,732	2,144	44,587	30.00
31.00	03100	INTENSIVE CARE UNIT	1,486	1,410	216	98	2,048	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,865	6,833	0	1,650	34,312	50.00
51.00	05100	RECOVERY ROOM	0	589	0	93	1,943	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,205	4,226	0	1,375	28,595	54.00
54.01	05401	ONCOLOGY	0	3,885	0	634	13,179	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
60.00	06000	LABORATORY	0	2,811	0	1,498	31,150	60.00
65.00	06500	RESPIRATORY THERAPY	240	140	0	301	6,270	65.00
66.00	06600	PHYSICAL THERAPY	561	1,976	0	479	9,956	66.00
67.00	06700	OCCUPATIONAL THERAPY	258	863	0	271	5,628	67.00
68.00	06800	SPEECH PATHOLOGY	11	181	0	134	2,791	68.00
69.00	06900	ELECTROCARDIOLOGY	0	896	0	202	4,192	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	327	0	96	2,003	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	6,503	0	2,686	0	88.00
90.00	09000	CLINIC	0	9,639	0	1,626	0	90.00
90.01	09001	SURGICAL ASSOCIATES	0	1,656	0	182	0	90.01
90.02	09002	ORTHOPAEDICS	0	1,030	0	281	0	90.02
90.03	09003	RHEUMATOLOGY	0	2,266	0	301	0	90.03
90.04	09004	SPECIALTY CLINIC	0	3,187	0	1,023	0	90.04
90.05	09005	PEDIATRICS	0	3,359	0	506	0	90.05
90.06	09006	WOMEN'S HEALTH	0	0	0	0	0	90.06
90.07	09007	PAIN MANAGEMENT	0	1,539	0	407	0	90.07
90.08	09008	ONCOLOGY MD	0	0	0	0	0	90.08
91.00	09100	EMERGENCY	2,955	4,000	0	1,356	28,199	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	1,787	0	582	12,104	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	28,495	79,237	3,948	19,690	226,957	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	FOUNDATION	0	1,915	0	221	0	193.01
193.02	19302	OCCUPATIONAL MEDICINE	0	0	0	0	0	193.02
193.03	19303	GUEST MEALS	0	0	0	0	0	193.03
194.00	07950	NON REIMBURSABLE	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	136,996	1,550,604	539,398	497,507	269,222	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	4.807721	19.107403	136.625633	24.986540	1.186225	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	652	83,477	93,027	24,993	4,847	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.022881	1.028650	23.563070	1.255236	0.021356	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00

COST ALLOCATION - STATISTICAL BASIS	Provider CCN: 15-1304	Period: From 01/01/2022 To 12/31/2022	Worksheet B-1 Date/Time Prepared: 5/18/2023 12:26 pm

		Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	
			8.00	9.00	10.00	11.00	13.00	
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1304 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B-1 | Date/Time Prepared: 5/18/2023 12:26 pm

		Cost Center Description	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	
			14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW 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	3,849,369			14.00
15.00	01500	PHARMACY	17,773	100		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	865	0	51,222,227	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	35,850	0	5,552,436	30.00
31.00	03100	INTENSIVE CARE UNIT	1,092	0	187,832	31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	878,402	0	0	50.00
51.00	05100	RECOVERY ROOM	19,256	0	2,374,966	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	50,734	0	34,536,401	54.00
54.01	05401	ONCOLOGY	16,713	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	55.00
60.00	06000	LABORATORY	623,317	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	10,398	0	664,395	65.00
66.00	06600	PHYSICAL THERAPY	3,866	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,698	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,002	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	10,648	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	918,327	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,081,608	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,867	100	0	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	30,491	0	0	88.00
90.00	09000	CLINIC	24,262	0	0	90.00
90.01	09001	SURGICAL ASSOCIATES	1,261	0	0	90.01
90.02	09002	ORTHOPAEDICS	958	0	0	90.02
90.03	09003	RHEUMATOLOGY	532	0	0	90.03
90.04	09004	SPECIALTY CLINIC	17,877	0	0	90.04
90.05	09005	PEDIATRICS	5,646	0	0	90.05
90.06	09006	WOMEN'S HEALTH	0	0	0	90.06
90.07	09007	PAIN MANAGEMENT	4,910	0	0	90.07
90.08	09008	ONCOLOGY MD	0	0	0	90.08
91.00	09100	EMERGENCY	81,945	0	7,906,197	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	4,071	0	0	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,849,369	100	51,222,227	118.00
		NONREIMBURSABLE COST CENTERS				
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	193.00
193.01	19301	FOUNDATION	0	0	0	193.01
193.02	19302	OCCUPATIONAL MEDICINE	0	0	0	193.02
193.03	19303	GUEST MEALS	0	0	0	193.03
194.00	07950	NON REIMBURSABLE	0	0	0	194.00
200.00		Cross Foot Adjustments				200.00
201.00		Negative Cost Centers				201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	435,216	1,099,565	939,601	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.113062	10,995.650000	0.018344	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	59,703	50,729	102,954	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.015510	507.290000	0.002010	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)				206.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1304 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B-1 | Date/Time Prepared: 5/18/2023 12:26 pm

		Cost Center Description	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)		
			14.00	15.00	16.00		
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)					207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-1304 | Period: From 01/01/2022 To 12/31/2022 | Worksheet C Part I | Date/Time Prepared: 5/18/2023 12:26 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,300,084		3,300,084	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	303,267		303,267	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,401,179		2,401,179	0	0	50.00
51.00	05100	RECOVERY ROOM	439,636		439,636	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,825,185		2,825,185	0	0	54.00
54.01	05401	ONCOLOGY	924,889		924,889	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0		0	0	0	55.00
60.00	06000	LABORATORY	3,036,995		3,036,995	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	413,075	0	413,075	0	0	65.00
66.00	06600	PHYSICAL THERAPY	700,309	0	700,309	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	456,169	0	456,169	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	106,022	0	106,022	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	334,019		334,019	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,083,343		2,083,343	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,409,508		1,409,508	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,093,405		7,093,405	0	0	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0		0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	3,572,782		3,572,782	0	0	88.00
90.00	09000	CLINIC	1,524,785		1,524,785	0	0	90.00
90.01	09001	SURGICAL ASSOCIATES	222,532		222,532	0	0	90.01
90.02	09002	ORTHOPAEDICS	312,513		312,513	0	0	90.02
90.03	09003	RHEUMATOLOGY	299,592		299,592	0	0	90.03
90.04	09004	SPECIALTY CLINIC	718,907		718,907	0	0	90.04
90.05	09005	PEDIATRICS	473,776		473,776	0	0	90.05
90.06	09006	WOMEN'S HEALTH	96,059		96,059	0	0	90.06
90.07	09007	PAIN MANAGEMENT	420,159		420,159	0	0	90.07
90.08	09008	ONCOLOGY MD	0		0	0	0	90.08
91.00	09100	EMERGENCY	4,026,361		4,026,361	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,075,189		1,075,189		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	683,564		683,564	0	0	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0		0		0	102.00
200.00		Subtotal (see instructions)	39,253,304	0	39,253,304	0	0	200.00
201.00		Less Observation Beds	1,075,189		1,075,189		0	201.00
202.00		Total (see instructions)	38,178,115	0	38,178,115	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1304 | Period: From 01/01/2022 To 12/31/2022 | Worksheet C Part I Date/Time Prepared: 5/18/2023 12:26 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,611,902		3,611,902			30.00
31.00	03100	INTENSIVE CARE UNIT	176,382		176,382			31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	432,136	10,036,675	10,468,811	0.229365	0.000000	50.00
51.00	05100	RECOVERY ROOM	109,547	2,265,419	2,374,966	0.185113	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	890,131	27,490,834	28,380,965	0.099545	0.000000	54.00
54.01	05401	ONCOLOGY	187	659,677	659,864	1.401636	0.000000	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0.000000	0.000000	55.00
60.00	06000	LABORATORY	1,091,539	12,852,699	13,944,238	0.217796	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	296,577	270,561	567,138	0.728350	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	219,423	1,923,358	2,142,781	0.326822	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	208,567	1,340,714	1,549,281	0.294439	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	30,292	236,840	267,132	0.396890	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	296,128	3,541,515	3,837,643	0.087038	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	266,841	5,912,360	6,179,201	0.337154	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	105,803	4,626,616	4,732,419	0.297841	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,151,881	17,616,961	18,768,842	0.377935	0.000000	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0.000000	0.000000	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	1,754,918	1,754,918			88.00
90.00	09000	CLINIC	0	846,536	846,536	1.801205	0.000000	90.00
90.01	09001	SURGICAL ASSOCIATES	0	16,012	16,012	13.897827	0.000000	90.01
90.02	09002	ORTHOPAEDICS	0	92,267	92,267	3.387051	0.000000	90.02
90.03	09003	RHEUMATOLOGY	0	45,040	45,040	6.651687	0.000000	90.03
90.04	09004	SPECIALTY CLINIC	0	135,950	135,950	5.288025	0.000000	90.04
90.05	09005	PEDIATRICS	0	237,380	237,380	1.995855	0.000000	90.05
90.06	09006	WOMEN'S HEALTH	0	11,346	11,346	8.466332	0.000000	90.06
90.07	09007	PAIN MANAGEMENT	0	87,823	87,823	4.784157	0.000000	90.07
90.08	09008	ONCOLOGY MD	0	0	0	0.000000	0.000000	90.08
91.00	09100	EMERGENCY	112,725	8,164,710	8,277,435	0.486426	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	15,101	1,124,819	1,139,920	0.943214	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	705,097	705,097	0.969461	0.000000	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0			102.00
200.00		Subtotal (see instructions)	9,015,162	101,996,127	111,011,289			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	9,015,162	101,996,127	111,011,289			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-1304 | Period: From 01/01/2022 To 12/31/2022 | Worksheet C Part I | Date/Time Prepared: 5/18/2023 12:26 pm

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
51.00	05100	RECOVERY ROOM	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
54.01	05401	ONCOLOGY	0.000000	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	55.00
60.00	06000	LABORATORY	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	77.00
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC		88.00
90.00	09000	CLINIC	0.000000	90.00
90.01	09001	SURGICAL ASSOCIATES	0.000000	90.01
90.02	09002	ORTHOPAEDICS	0.000000	90.02
90.03	09003	RHEUMATOLOGY	0.000000	90.03
90.04	09004	SPECIALTY CLINIC	0.000000	90.04
90.05	09005	PEDIATRICS	0.000000	90.05
90.06	09006	WOMEN'S HEALTH	0.000000	90.06
90.07	09007	PAIN MANAGEMENT	0.000000	90.07
90.08	09008	ONCOLOGY MD	0.000000	90.08
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS		
95.00	09500	AMBULANCE SERVICES	0.000000	95.00
102.00	10200	OPIOID TREATMENT PROGRAM		102.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-1304 | Period: From 01/01/2022 To 12/31/2022 | Worksheet C Part I | Date/Time Prepared: 5/18/2023 12:26 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Disallowance	Total Costs	
					Costs			
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,300,084		3,300,084	0	3,300,084	30.00
31.00	03100	INTENSIVE CARE UNIT	303,267		303,267	0	303,267	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,401,179		2,401,179	0	2,401,179	50.00
51.00	05100	RECOVERY ROOM	439,636		439,636	0	439,636	51.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,825,185		2,825,185	0	2,825,185	54.00
54.01	05401	ONCOLOGY	924,889		924,889	0	924,889	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0		0	0	0	55.00
60.00	06000	LABORATORY	3,036,995		3,036,995	0	3,036,995	60.00
65.00	06500	RESPIRATORY THERAPY	413,075	0	413,075	0	413,075	65.00
66.00	06600	PHYSICAL THERAPY	700,309	0	700,309	0	700,309	66.00
67.00	06700	OCCUPATIONAL THERAPY	456,169	0	456,169	0	456,169	67.00
68.00	06800	SPEECH PATHOLOGY	106,022	0	106,022	0	106,022	68.00
69.00	06900	ELECTROCARDIOLOGY	334,019		334,019	0	334,019	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,083,343		2,083,343	0	2,083,343	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,409,508		1,409,508	0	1,409,508	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,093,405		7,093,405	0	7,093,405	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0		0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	3,572,782		3,572,782	0	3,572,782	88.00
90.00	09000	CLINIC	1,524,785		1,524,785	0	1,524,785	90.00
90.01	09001	SURGICAL ASSOCIATES	222,532		222,532	0	222,532	90.01
90.02	09002	ORTHOPAEDICS	312,513		312,513	0	312,513	90.02
90.03	09003	RHEUMATOLOGY	299,592		299,592	0	299,592	90.03
90.04	09004	SPECIALTY CLINIC	718,907		718,907	0	718,907	90.04
90.05	09005	PEDIATRICS	473,776		473,776	0	473,776	90.05
90.06	09006	WOMEN'S HEALTH	96,059		96,059	0	96,059	90.06
90.07	09007	PAIN MANAGEMENT	420,159		420,159	0	420,159	90.07
90.08	09008	ONCOLOGY MD	0		0	0	0	90.08
91.00	09100	EMERGENCY	4,026,361		4,026,361	0	4,026,361	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,075,189		1,075,189		1,075,189	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	683,564		683,564	0	683,564	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0		0		0	102.00
200.00		Subtotal (see instructions)	39,253,304	0	39,253,304	0	39,253,304	200.00
201.00		Less Observation Beds	1,075,189		1,075,189		1,075,189	201.00
202.00		Total (see instructions)	38,178,115	0	38,178,115	0	38,178,115	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1304 | Period: From 01/01/2022 To 12/31/2022 | Worksheet C Part I | Date/Time Prepared: 5/18/2023 12:26 pm

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,611,902		3,611,902			30.00
31.00	03100	INTENSIVE CARE UNIT	176,382		176,382			31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	432,136	10,036,675	10,468,811	0.229365	0.000000	50.00
51.00	05100	RECOVERY ROOM	109,547	2,265,419	2,374,966	0.185113	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	890,131	27,490,834	28,380,965	0.099545	0.000000	54.00
54.01	05401	ONCOLOGY	187	659,677	659,864	1.401636	0.000000	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0.000000	0.000000	55.00
60.00	06000	LABORATORY	1,091,539	12,852,699	13,944,238	0.217796	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	296,577	270,561	567,138	0.728350	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	219,423	1,923,358	2,142,781	0.326822	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	208,567	1,340,714	1,549,281	0.294439	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	30,292	236,840	267,132	0.396890	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	296,128	3,541,515	3,837,643	0.087038	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	266,841	5,912,360	6,179,201	0.337154	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	105,803	4,626,616	4,732,419	0.297841	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,151,881	17,616,961	18,768,842	0.377935	0.000000	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0.000000	0.000000	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	1,754,918	1,754,918	2.035868	0.000000	88.00
90.00	09000	CLINIC	0	846,536	846,536	1.801205	0.000000	90.00
90.01	09001	SURGICAL ASSOCIATES	0	16,012	16,012	13.897827	0.000000	90.01
90.02	09002	ORTHOPAEDICS	0	92,267	92,267	3.387051	0.000000	90.02
90.03	09003	RHEUMATOLOGY	0	45,040	45,040	6.651687	0.000000	90.03
90.04	09004	SPECIALTY CLINIC	0	135,950	135,950	5.288025	0.000000	90.04
90.05	09005	PEDIATRICS	0	237,380	237,380	1.995855	0.000000	90.05
90.06	09006	WOMEN'S HEALTH	0	11,346	11,346	8.466332	0.000000	90.06
90.07	09007	PAIN MANAGEMENT	0	87,823	87,823	4.784157	0.000000	90.07
90.08	09008	ONCOLOGY MD	0	0	0	0.000000	0.000000	90.08
91.00	09100	EMERGENCY	112,725	8,164,710	8,277,435	0.486426	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	15,101	1,124,819	1,139,920	0.943214	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	705,097	705,097	0.969461	0.000000	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0			102.00
200.00		Subtotal (see instructions)	9,015,162	101,996,127	111,011,289			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	9,015,162	101,996,127	111,011,289			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-1304 | Period: From 01/01/2022 To 12/31/2022 | Worksheet C Part I | Date/Time Prepared: 5/18/2023 12:26 pm

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
51.00	05100	RECOVERY ROOM	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
54.01	05401	ONCOLOGY	0.000000	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	55.00
60.00	06000	LABORATORY	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	77.00
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC	0.000000	88.00
90.00	09000	CLINIC	0.000000	90.00
90.01	09001	SURGICAL ASSOCIATES	0.000000	90.01
90.02	09002	ORTHOPAEDICS	0.000000	90.02
90.03	09003	RHEUMATOLOGY	0.000000	90.03
90.04	09004	SPECIALTY CLINIC	0.000000	90.04
90.05	09005	PEDIATRICS	0.000000	90.05
90.06	09006	WOMEN'S HEALTH	0.000000	90.06
90.07	09007	PAIN MANAGEMENT	0.000000	90.07
90.08	09008	ONCOLOGY MD	0.000000	90.08
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS		
95.00	09500	AMBULANCE SERVICES	0.000000	95.00
102.00	10200	OPIOID TREATMENT PROGRAM		102.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-1304 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part II Date/Time Prepared: 5/18/2023 12:26 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	190,527	10,468,811	0.018199	177,427	3,229	50.00
51.00	05100	RECOVERY ROOM	21,605	2,374,966	0.009097	31,444	286	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	186,075	28,380,965	0.006556	283,231	1,857	54.00
54.01	05401	ONCOLOGY	97,589	659,864	0.147893	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0.000000	0	0	55.00
60.00	06000	LABORATORY	94,859	13,944,238	0.006803	429,941	2,925	60.00
65.00	06500	RESPIRATORY THERAPY	7,857	567,138	0.013854	104,272	1,445	65.00
66.00	06600	PHYSICAL THERAPY	51,445	2,142,781	0.024009	119,597	2,871	66.00
67.00	06700	OCCUPATIONAL THERAPY	23,649	1,549,281	0.015265	111,544	1,703	67.00
68.00	06800	SPEECH PATHOLOGY	5,140	267,132	0.019241	16,410	316	68.00
69.00	06900	ELECTROCARDIOLOGY	23,349	3,837,643	0.006084	167,063	1,016	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	23,657	6,179,201	0.003828	33,863	130	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	22,897	4,732,419	0.004838	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	87,268	18,768,842	0.004650	475,340	2,210	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0.000000	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	179,074	1,754,918	0.102041	0	0	88.00
90.00	09000	CLINIC	237,961	846,536	0.281100	0	0	90.00
90.01	09001	SURGICAL ASSOCIATES	40,174	16,012	2.508993	0	0	90.01
90.02	09002	ORTHOPAEDICS	27,963	92,267	0.303066	0	0	90.02
90.03	09003	RHEUMATOLOGY	56,347	45,040	1.251044	0	0	90.03
90.04	09004	SPECIALTY CLINIC	82,930	135,950	0.610004	0	0	90.04
90.05	09005	PEDIATRICS	83,094	237,380	0.350046	0	0	90.05
90.06	09006	WOMEN'S HEALTH	1,508	11,346	0.132910	0	0	90.06
90.07	09007	PAIN MANAGEMENT	40,788	87,823	0.464434	0	0	90.07
90.08	09008	ONCOLOGY MD	0	0	0.000000	0	0	90.08
91.00	09100	EMERGENCY	134,477	8,277,435	0.016246	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	92,142	1,139,920	0.080832	783	63	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	1,812,375	106,517,908		1,950,915	18,051	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1304 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part IV | Date/Time Prepared: 5/18/2023 12:26 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	ONCOLOGY	0	0	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	SURGICAL ASSOCIATES	0	0	0	0	0	90.01
90.02	09002	ORTHOPAEDICS	0	0	0	0	0	90.02
90.03	09003	RHEUMATOLOGY	0	0	0	0	0	90.03
90.04	09004	SPECIALTY CLINIC	0	0	0	0	0	90.04
90.05	09005	PEDIATRICS	0	0	0	0	0	90.05
90.06	09006	WOMEN'S HEALTH	0	0	0	0	0	90.06
90.07	09007	PAIN MANAGEMENT	0	0	0	0	0	90.07
90.08	09008	ONCOLOGY MD	0	0	0	0	0	90.08
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1304

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

Worksheet D Part IV

Date/Time Prepared: 5/18/2023 12:26 pm

Title XVIII | Hospital | Cost

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	10,468,811	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	2,374,966	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	28,380,965	0.000000	54.00
54.01	05401	ONCOLOGY	0	0	0	659,864	0.000000	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0.000000	55.00
60.00	06000	LABORATORY	0	0	0	13,944,238	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	567,138	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,142,781	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,549,281	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	267,132	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	3,837,643	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	6,179,201	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	4,732,419	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	18,768,842	0.000000	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0.000000	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	1,754,918	0.000000	88.00
90.00	09000	CLINIC	0	0	0	846,536	0.000000	90.00
90.01	09001	SURGICAL ASSOCIATES	0	0	0	16,012	0.000000	90.01
90.02	09002	ORTHOPAEDICS	0	0	0	92,267	0.000000	90.02
90.03	09003	RHEUMATOLOGY	0	0	0	45,040	0.000000	90.03
90.04	09004	SPECIALTY CLINIC	0	0	0	135,950	0.000000	90.04
90.05	09005	PEDIATRICS	0	0	0	237,380	0.000000	90.05
90.06	09006	WOMEN'S HEALTH	0	0	0	11,346	0.000000	90.06
90.07	09007	PAIN MANAGEMENT	0	0	0	87,823	0.000000	90.07
90.08	09008	ONCOLOGY MD	0	0	0	0	0.000000	90.08
91.00	09100	EMERGENCY	0	0	0	8,277,435	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	1,139,920	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	106,517,908		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1304 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part IV Date/Time Prepared: 5/18/2023 12:26 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	177,427	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	31,444	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	283,231	0	0	0	54.00
54.01	05401	ONCOLOGY	0.000000	0	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	55.00
60.00	06000	LABORATORY	0.000000	429,941	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	104,272	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	119,597	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	111,544	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	16,410	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	167,063	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	33,863	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	475,340	0	0	0	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	SURGICAL ASSOCIATES	0.000000	0	0	0	0	90.01
90.02	09002	ORTHOPAEDICS	0.000000	0	0	0	0	90.02
90.03	09003	RHEUMATOLOGY	0.000000	0	0	0	0	90.03
90.04	09004	SPECIALTY CLINIC	0.000000	0	0	0	0	90.04
90.05	09005	PEDIATRICS	0.000000	0	0	0	0	90.05
90.06	09006	WOMEN'S HEALTH	0.000000	0	0	0	0	90.06
90.07	09007	PAIN MANAGEMENT	0.000000	0	0	0	0	90.07
90.08	09008	ONCOLOGY MD	0.000000	0	0	0	0	90.08
91.00	09100	EMERGENCY	0.000000	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	783	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		1,950,915	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-1304 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part V | Date/Time Prepared: 5/18/2023 12:26 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.229365	0	3,755,175	0	0	50.00
51.00	05100	RECOVERY ROOM	0.185113	0	339,789	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.099545	0	6,248,924	0	0	54.00
54.01	05401	ONCOLOGY	1.401636	0	175,194	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	55.00
60.00	06000	LABORATORY	0.217796	0	3,091,993	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.728350	0	44,658	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.326822	0	568,194	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.294439	0	343,291	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.396890	0	88,290	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.087038	0	1,063,637	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.337154	0	29,777	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.297841	0	480,654	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.377935	0	8,429,277	29,996	0	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC						88.00
90.00	09000	CLINIC	1.801205	0	36,000	0	0	90.00
90.01	09001	SURGICAL ASSOCIATES	13.897827	0	6,922	0	0	90.01
90.02	09002	ORTHOPAEDICS	3.387051	0	57,075	0	0	90.02
90.03	09003	RHEUMATOLOGY	6.651687	0	28,561	0	0	90.03
90.04	09004	SPECIALTY CLINIC	5.288025	0	77,944	0	0	90.04
90.05	09005	PEDIATRICS	1.995855	0	0	0	0	90.05
90.06	09006	WOMEN'S HEALTH	8.466332	0	1,182	0	0	90.06
90.07	09007	PAIN MANAGEMENT	4.784157	0	17,916	0	0	90.07
90.08	09008	ONCOLOGY MD	0.000000	0	0	0	0	90.08
91.00	09100	EMERGENCY	0.486426	0	1,271,329	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.943214	0	263,376	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.969461		0			95.00
200.00		Subtotal (see instructions)		0	26,419,158	29,996	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	26,419,158	29,996	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1304 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part V Date/Time Prepared: 5/18/2023 12:26 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Costs		
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	861,306	0	50.00
51.00	05100	RECOVERY ROOM	62,899	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	622,049	0	54.00
54.01	05401	ONCOLOGY	245,558	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	55.00
60.00	06000	LABORATORY	673,424	0	60.00
65.00	06500	RESPIRATORY THERAPY	32,527	0	65.00
66.00	06600	PHYSICAL THERAPY	185,698	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	101,078	0	67.00
68.00	06800	SPEECH PATHOLOGY	35,041	0	68.00
69.00	06900	ELECTROCARDIOLOGY	92,577	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	10,039	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	143,158	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,185,719	11,337	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC			88.00
90.00	09000	CLINIC	64,843	0	90.00
90.01	09001	SURGICAL ASSOCIATES	96,201	0	90.01
90.02	09002	ORTHOPAEDICS	193,316	0	90.02
90.03	09003	RHEUMATOLOGY	189,979	0	90.03
90.04	09004	SPECIALTY CLINIC	412,170	0	90.04
90.05	09005	PEDIATRICS	0	0	90.05
90.06	09006	WOMEN'S HEALTH	10,007	0	90.06
90.07	09007	PAIN MANAGEMENT	85,713	0	90.07
90.08	09008	ONCOLOGY MD	0	0	90.08
91.00	09100	EMERGENCY	618,407	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	248,420	0	92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0		95.00
200.00		Subtotal (see instructions)	8,170,129	11,337	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	8,170,129	11,337	202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-1304 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part I Date/Time Prepared: 5/18/2023 12:26 pm

Title XIX | Hospital | Cost

	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	282,809	1,520	281,289	1,850	152.05	30.00
31.00	INTENSIVE CARE UNIT	40,114		40,114	72	557.14	31.00
200.00	Total (lines 30 through 199)	322,923		321,403	1,922		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	
		6.00	7.00	
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	8	1,216	30.00
31.00	INTENSIVE CARE UNIT	0	0	31.00
200.00	Total (lines 30 through 199)	8	1,216	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 15-1304

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

Worksheet D Part II

Date/Time Prepared: 5/18/2023 12:26 pm

Title XIX | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	190,527	10,468,811	0.018199	0	0	50.00
51.00	05100	RECOVERY ROOM	21,605	2,374,966	0.009097	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	186,075	28,380,965	0.006556	89,308	586	54.00
54.01	05401	ONCOLOGY	97,589	659,864	0.147893	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0.000000	0	0	55.00
60.00	06000	LABORATORY	94,859	13,944,238	0.006803	22,165	151	60.00
65.00	06500	RESPIRATORY THERAPY	7,857	567,138	0.013854	398	6	65.00
66.00	06600	PHYSICAL THERAPY	51,445	2,142,781	0.024009	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	23,649	1,549,281	0.015265	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	5,140	267,132	0.019241	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	23,349	3,837,643	0.006084	223	1	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	23,657	6,179,201	0.003828	16	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	22,897	4,732,419	0.004838	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	87,268	18,768,842	0.004650	12,676	59	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0.000000	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	179,074	1,754,918	0.102041	0	0	88.00
90.00	09000	CLINIC	237,961	846,536	0.281100	0	0	90.00
90.01	09001	SURGICAL ASSOCIATES	40,174	16,012	2.508993	0	0	90.01
90.02	09002	ORTHOPAEDICS	27,963	92,267	0.303066	0	0	90.02
90.03	09003	RHEUMATOLOGY	56,347	45,040	1.251044	0	0	90.03
90.04	09004	SPECIALTY CLINIC	82,930	135,950	0.610004	0	0	90.04
90.05	09005	PEDIATRICS	83,094	237,380	0.350046	0	0	90.05
90.06	09006	WOMEN'S HEALTH	1,508	11,346	0.132910	0	0	90.06
90.07	09007	PAIN MANAGEMENT	40,788	87,823	0.464434	0	0	90.07
90.08	09008	ONCOLOGY MD	0	0	0.000000	0	0	90.08
91.00	09100	EMERGENCY	134,477	8,277,435	0.016246	7,465	121	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	92,142	1,139,920	0.080832	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	1,812,375	106,517,908		132,251	924	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1304 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part III Date/Time Prepared: 5/18/2023 12:26 pm

Title XIX | Hospital | Cost

		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	1,850	0.00	8	30.00
31.00	03100	INTENSIVE CARE UNIT		0	72	0.00	0	31.00
200.00		Total (lines 30 through 199)		0	1,922		8	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: 15-1304 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part IV | Date/Time Prepared: 5/18/2023 12:26 pm

Title XIX | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	ONCOLOGY	0	0	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	SURGICAL ASSOCIATES	0	0	0	0	0	90.01
90.02	09002	ORTHOPAEDICS	0	0	0	0	0	90.02
90.03	09003	RHEUMATOLOGY	0	0	0	0	0	90.03
90.04	09004	SPECIALTY CLINIC	0	0	0	0	0	90.04
90.05	09005	PEDIATRICS	0	0	0	0	0	90.05
90.06	09006	WOMEN'S HEALTH	0	0	0	0	0	90.06
90.07	09007	PAIN MANAGEMENT	0	0	0	0	0	90.07
90.08	09008	ONCOLOGY MD	0	0	0	0	0	90.08
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1304 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part IV | Date/Time Prepared: 5/18/2023 12:26 pm

Title XIX | Hospital | Cost

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	10,468,811	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	2,374,966	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	28,380,965	0.000000	54.00
54.01	05401	ONCOLOGY	0	0	0	659,864	0.000000	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0.000000	55.00
60.00	06000	LABORATORY	0	0	0	13,944,238	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	567,138	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,142,781	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,549,281	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	267,132	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	3,837,643	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	6,179,201	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	4,732,419	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	18,768,842	0.000000	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0.000000	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	1,754,918	0.000000	88.00
90.00	09000	CLINIC	0	0	0	846,536	0.000000	90.00
90.01	09001	SURGICAL ASSOCIATES	0	0	0	16,012	0.000000	90.01
90.02	09002	ORTHOPAEDICS	0	0	0	92,267	0.000000	90.02
90.03	09003	RHEUMATOLOGY	0	0	0	45,040	0.000000	90.03
90.04	09004	SPECIALTY CLINIC	0	0	0	135,950	0.000000	90.04
90.05	09005	PEDIATRICS	0	0	0	237,380	0.000000	90.05
90.06	09006	WOMEN'S HEALTH	0	0	0	11,346	0.000000	90.06
90.07	09007	PAIN MANAGEMENT	0	0	0	87,823	0.000000	90.07
90.08	09008	ONCOLOGY MD	0	0	0	0	0.000000	90.08
91.00	09100	EMERGENCY	0	0	0	8,277,435	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	1,139,920	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	106,517,908		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1304 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part IV | Date/Time Prepared: 5/18/2023 12:26 pm

Title XIX | Hospital | Cost

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	89,308	0	0	0	54.00
54.01	05401	ONCOLOGY	0.000000	0	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	55.00
60.00	06000	LABORATORY	0.000000	22,165	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	398	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	223	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	16	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	12,676	0	0	0	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	SURGICAL ASSOCIATES	0.000000	0	0	0	0	90.01
90.02	09002	ORTHOPAEDICS	0.000000	0	0	0	0	90.02
90.03	09003	RHEUMATOLOGY	0.000000	0	0	0	0	90.03
90.04	09004	SPECIALTY CLINIC	0.000000	0	0	0	0	90.04
90.05	09005	PEDIATRICS	0.000000	0	0	0	0	90.05
90.06	09006	WOMEN'S HEALTH	0.000000	0	0	0	0	90.06
90.07	09007	PAIN MANAGEMENT	0.000000	0	0	0	0	90.07
90.08	09008	ONCOLOGY MD	0.000000	0	0	0	0	90.08
91.00	09100	EMERGENCY	0.000000	7,465	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		132,251	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1304 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-1 | Date/Time Prepared: 5/18/2023 12:26 pm

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	1,866	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,850	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,244	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	10	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	6	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)	587	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)	10	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	3,300,084	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)	17,742	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,282,342	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	3,282,342	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)	1,774.24	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,041,479	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	1,041,479	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1304 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-1 | Date/Time Prepared: 5/18/2023 12:26 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	303,267	72	4,212.04	11	46,332	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)	529,085	48.00
48.01	Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)	0	48.01
49.00	Total Program inpatient costs (sum of lines 41 through 48.01)(see instructions)	1,616,896	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)	17,742	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	17,742	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)	606	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,774.24	88.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-1304	Period: From 01/01/2022 To 12/31/2022	Worksheet D-1 Date/Time Prepared: 5/18/2023 12:26 pm
	Title XVIII	Hospital	Cost

	Cost Center Description	1.00	
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,075,189	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	282,809	3,300,084	0.085698	1,075,189	92,142	90.00
91.00	Nursing Program cost	0	3,300,084	0.000000	1,075,189	0	91.00
92.00	Allied health cost	0	3,300,084	0.000000	1,075,189	0	92.00
93.00	All other Medical Education	0	3,300,084	0.000000	1,075,189	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1304 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-1 | Date/Time Prepared: 5/18/2023 12:26 pm

Title XIX | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	1,866	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,850	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,244	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	10	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	6	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	8	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		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	3,300,084	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)	17,742	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,282,342	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	3,282,342	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)	1,774.24	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	14,194	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)	14,194	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1304 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-1 | Date/Time Prepared: 5/18/2023 12:26 pm

Title XIX | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	303,267	72	4,212.04	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)	22,453	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)	36,647	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)	606	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,774.24	88.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-1304	Period: From 01/01/2022 To 12/31/2022	Worksheet D-1 Date/Time Prepared: 5/18/2023 12:26 pm
	Title XIX	Hospital	Cost

	Cost Center Description	1.00	
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,075,189	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	282,809	3,300,084	0.085698	1,075,189	92,142	90.00
91.00	Nursing Program cost	0	3,300,084	0.000000	1,075,189	0	91.00
92.00	Allied health cost	0	3,300,084	0.000000	1,075,189	0	92.00
93.00	All other Medical Education	0	3,300,084	0.000000	1,075,189	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1304 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-3 Date/Time Prepared: 5/18/2023 12:26 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		1,121,715		30.00
31.00	03100	INTENSIVE CARE UNIT		32,337		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.229365	177,427	40,696	50.00
51.00	05100	RECOVERY ROOM	0.185113	31,444	5,821	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.099545	283,231	28,194	54.00
54.01	05401	ONCOLOGY	1.401636	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	55.00
60.00	06000	LABORATORY	0.217796	429,941	93,639	60.00
65.00	06500	RESPIRATORY THERAPY	0.728350	104,272	75,947	65.00
66.00	06600	PHYSICAL THERAPY	0.326822	119,597	39,087	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.294439	111,544	32,843	67.00
68.00	06800	SPEECH PATHOLOGY	0.396890	16,410	6,513	68.00
69.00	06900	ELECTROCARDIOLOGY	0.087038	167,063	14,541	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.337154	33,863	11,417	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.297841	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.377935	475,340	179,648	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	1.801205	0	0	90.00
90.01	09001	SURGICAL ASSOCIATES	13.897827	0	0	90.01
90.02	09002	ORTHOPAEDICS	3.387051	0	0	90.02
90.03	09003	RHEUMATOLOGY	6.651687	0	0	90.03
90.04	09004	SPECIALTY CLINIC	5.288025	0	0	90.04
90.05	09005	PEDIATRICS	1.995855	0	0	90.05
90.06	09006	WOMEN'S HEALTH	8.466332	0	0	90.06
90.07	09007	PAIN MANAGEMENT	4.784157	0	0	90.07
90.08	09008	ONCOLOGY MD	0.000000	0	0	90.08
91.00	09100	EMERGENCY	0.486426	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.943214	783	739	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,950,915	529,085	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)		1,950,915		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 15-1304 Component CCN: 15-Z304	Period: From 01/01/2022 To 12/31/2022	Worksheet D-3 Date/Time Prepared: 5/18/2023 12:26 pm
	Title XVIII	Swing Beds - SNF	Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.229365	0	0	50.00
51.00	05100	RECOVERY ROOM	0.185113	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.099545	723	72	54.00
54.01	05401	ONCOLOGY	1.401636	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	55.00
60.00	06000	LABORATORY	0.217796	1,850	403	60.00
65.00	06500	RESPIRATORY THERAPY	0.728350	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.326822	1,399	457	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.294439	2,018	594	67.00
68.00	06800	SPEECH PATHOLOGY	0.396890	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.087038	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.337154	43	14	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.297841	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.377935	5,267	1,991	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	1.801205	0	0	90.00
90.01	09001	SURGICAL ASSOCIATES	13.897827	0	0	90.01
90.02	09002	ORTHOPAEDICS	3.387051	0	0	90.02
90.03	09003	RHEUMATOLOGY	6.651687	0	0	90.03
90.04	09004	SPECIALTY CLINIC	5.288025	0	0	90.04
90.05	09005	PEDIATRICS	1.995855	0	0	90.05
90.06	09006	WOMEN'S HEALTH	8.466332	0	0	90.06
90.07	09007	PAIN MANAGEMENT	4.784157	0	0	90.07
90.08	09008	ONCOLOGY MD	0.000000	0	0	90.08
91.00	09100	EMERGENCY	0.486426	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.943214	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		11,300	3,531	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)		11,300		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1304 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-3 | Date/Time Prepared: 5/18/2023 12:26 pm

Title XIX | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		30,023		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.229365	0	0	50.00
51.00	05100	RECOVERY ROOM	0.185113	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.099545	89,308	8,890	54.00
54.01	05401	ONCOLOGY	1.401636	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	55.00
60.00	06000	LABORATORY	0.217796	22,165	4,827	60.00
65.00	06500	RESPIRATORY THERAPY	0.728350	398	290	65.00
66.00	06600	PHYSICAL THERAPY	0.326822	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.294439	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.396890	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.087038	223	19	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.337154	16	5	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.297841	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.377935	12,676	4,791	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	2.035868	0	0	88.00
90.00	09000	CLINIC	1.801205	0	0	90.00
90.01	09001	SURGICAL ASSOCIATES	13.897827	0	0	90.01
90.02	09002	ORTHOPAEDICS	3.387051	0	0	90.02
90.03	09003	RHEUMATOLOGY	6.651687	0	0	90.03
90.04	09004	SPECIALTY CLINIC	5.288025	0	0	90.04
90.05	09005	PEDIATRICS	1.995855	0	0	90.05
90.06	09006	WOMEN'S HEALTH	8.466332	0	0	90.06
90.07	09007	PAIN MANAGEMENT	4.784157	0	0	90.07
90.08	09008	ONCOLOGY MD	0.000000	0	0	90.08
91.00	09100	EMERGENCY	0.486426	7,465	3,631	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.943214	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		132,251	22,453	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)		132,251		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1304	Period: From 01/01/2022 To 12/31/2022	Worksheet E Part B Date/Time Prepared: 5/18/2023 12:26 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	8,181,466	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	OPPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	8,181,466	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	8,263,281	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	56,329	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	4,584,975	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	3,621,977	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	3,621,977	30.00
31.00	Primary payer payments	403	31.00
32.00	Subtotal (line 30 minus line 31)	3,621,574	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)	511,399	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	332,409	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	482,513	36.00
37.00	Subtotal (see instructions)	3,953,983	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.75	N95 respirator payment adjustment amount (see instructions)	0	39.75
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	3,953,983	40.00
40.01	Sequestration adjustment (see instructions)	49,820	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
40.03	Sequestration adjustment-PARHM or CHART pass-throughs		40.03
41.00	Interim payments	3,889,080	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)	15,083	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: 15-1304	Period: From 01/01/2022 To 12/31/2022	Worksheet E Part B Date/Time Prepared: 5/18/2023 12:26 pm
	Title XVIII	Hospital	Cost

		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: 15-1304 | Period: From 01/01/2022 To 12/31/2022 | Worksheet E-1 Part I Date/Time Prepared: 5/18/2023 12:26 pm

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,265,529		3,889,080	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	09/14/2022	102,200		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		102,200		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,367,729		3,889,080	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		19,812		15,083	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,387,541		3,904,163	7.00

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-1304 | Component CCN: 15-Z304 | Period: From 01/01/2022 To 12/31/2022 | Worksheet E-1 Part I | Date/Time Prepared: 5/18/2023 12:26 pm

Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		21,292		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		21,292		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		78		0	6.02
7.00	Total Medicare program liability (see instructions)		21,214		0	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-1304	Period: From 01/01/2022 To 12/31/2022	Worksheet E-1 Part II Date/Time Prepared: 5/18/2023 12:26 pm
	Title XVIII	Hospital	Cost

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

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS	Provider CCN: 15-1304 Component CCN: 15-Z304	Period: From 01/01/2022 To 12/31/2022	Worksheet E-2 Date/Time Prepared: 5/18/2023 12:26 pm
	Title XVIII	Swing Beds - SNF	Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	17,919	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swing-bed pass-through, see instructions)	3,566	0	3.00
3.01	Nursing and allied health payment-PARHM or CHART (see instructions)			3.01
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	10	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	21,485	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	21,485	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	21,485	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	0	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (see instructions)	21,485	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			16.50
16.55	Rural community hospital demonstration project (§410A Demonstration) payment adjustment (see instructions)	0		16.55
16.99	Demonstration payment adjustment amount before sequestration	0	0	16.99
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	21,485	0	19.00
19.01	Sequestration adjustment (see instructions)	271	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0	0	19.02
19.03	Sequestration adjustment-PARHM or CHART pass-throughs			19.03
19.25	Sequestration for non-claims based amounts (see instructions)	0	0	19.25
20.00	Interim payments	21,292	0	20.00
20.01	Interim payments-PARHM or CHART			20.01
21.00	Tentative settlement (for contractor use only)	0	0	21.00
21.01	Tentative settlement-PARHM or CHART (for contractor use only)			21.01
22.00	Balance due provider/program (line 19 minus lines 19.01, 19.02, 19.25, 20, and 21)	-78	0	22.00
22.01	Balance due provider/program-PARHM or CHART (see instructions)			22.01
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	23.00
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
	Cost Reimbursement			
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))			201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))			202.00
203.00	Total (sum of lines 201 and 202)			203.00
204.00	Medicare swing-bed SNF discharges (see instructions)			204.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
205.00	Medicare swing-bed SNF target amount			205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)			206.00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)			208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
	Comparision of PPS versus Cost Reimbursement			
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)			215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1304	Period: From 01/01/2022 To 12/31/2022	Worksheet E-3 Part V Date/Time Prepared: 5/18/2023 12:26 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	1,616,896	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)	0	2.00
3.00	Organ acquisition	0	3.00
3.01	Cellular therapy acquisition cost (see instructions)	0	3.01
4.00	Subtotal (sum of lines 1 through 3.01)	1,616,896	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	1,633,065	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	1,633,065	19.00
20.00	Deductibles (exclude professional component)	236,889	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	1,396,176	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	1,396,176	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	13,956	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	9,071	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	10,002	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	1,405,247	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29.98	Recovery of accelerated depreciation.	0	29.98
29.99	Demonstration payment adjustment amount before sequestration	0	29.99
30.00	Subtotal (see instructions)	1,405,247	30.00
30.01	Sequestration adjustment (see instructions)	17,706	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
30.03	Sequestration adjustment-PARHM or CHART		30.03
31.00	Interim payments	1,367,729	31.00
31.01	Interim payments-PARHM or CHART		31.01
32.00	Tentative settlement (for contractor use only)	0	32.00
32.01	Tentative settlement-PARHM or CHART (for contractor use only)		32.01
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)	19,812	33.00
33.01	Balance due provider/program-PARHM or CHART (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01)		33.01
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-1304 | Period: From 01/01/2022 To 12/31/2022 | Worksheet E-3 Part VII Date/Time Prepared: 5/18/2023 12:26 pm

Title XIX | Hospital | Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	36,647		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)	36,647	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)	36,647	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	132,251	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)	132,251	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)	132,251	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	95,604	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)	36,647	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)	36,647	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)	36,647	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	36,647	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	36,647	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)	36,647	0	40.00
41.00	Interim payments	0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	36,647	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

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

Provider CCN: 15-1304 | Period: From 01/01/2022 To 12/31/2022 | Worksheet G | Date/Time Prepared: 5/18/2023 12:26 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	12,680,299	0	0	0	1.00
2.00	Temporary investments	2,787,579	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	20,178,482	0	0	0	4.00
5.00	Other receivable	826,034	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-13,191,372	0	0	0	6.00
7.00	Inventory	1,291,008	0	0	0	7.00
8.00	Prepaid expenses	628,287	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	25,200,317	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	591,263	0	0	0	12.00
13.00	Land improvements	785,101	0	0	0	13.00
14.00	Accumulated depreciation	-714,202	0	0	0	14.00
15.00	Buildings	22,481,510	0	0	0	15.00
16.00	Accumulated depreciation	-5,749,129	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	6,250,139	0	0	0	19.00
20.00	Accumulated depreciation	-1,004,265	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	21,326,672	0	0	0	23.00
24.00	Accumulated depreciation	-21,680,360	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)	22,286,729	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	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	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	0	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	47,487,046	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1,889,570	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,870,257	0	0	0	38.00
39.00	Payroll taxes payable	1,144,839	0	0	0	39.00
40.00	Notes and loans payable (short term)	1,818,110	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	15,461,105	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	22,183,881	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	1,381,433	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	1,381,433	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	23,565,314	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	23,921,732				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)	23,921,732	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	47,487,046	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-1304 | Period: From 01/01/2022 To 12/31/2022 | Worksheet G-1 | Date/Time Prepared: 5/18/2023 12:26 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		23,623,297		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		298,435				2.00
3.00	Total (sum of line 1 and line 2)		23,921,732		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)		23,921,732		0		11.00
12.00	ROUNDING	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		23,921,732		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: 15-1304 | Period: From 01/01/2022 To 12/31/2022 | Worksheet G-2 Parts I & II Date/Time Prepared: 5/18/2023 12:26 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	2,822,424		2,822,424	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	2,822,424		2,822,424	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	176,382		176,382	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)	176,382		176,382	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	2,998,806		2,998,806	17.00
18.00	Ancillary services	5,408,187	111,592,715	117,000,902	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	2,732,785	2,732,785	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	705,097	705,097	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)	8,406,993	115,030,597	123,437,590	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		48,500,237		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)		48,500,237		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-1304 | Period: From 01/01/2022 To 12/31/2022 | Worksheet G-3 | Date/Time Prepared: 5/18/2023 12:26 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	123,437,590	1.00
2.00	Less contractual allowances and discounts on patients' accounts	77,159,732	2.00
3.00	Net patient revenues (line 1 minus line 2)	46,277,858	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	48,500,237	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-2,222,379	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	1,335,553	6.00
7.00	Income from investments	-414,017	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	165,049	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	78,279	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	5,403	16.00
17.00	Revenue from sale of drugs to other than patients	5,177	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	245,146	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER OPERATING INCOME	217,542	24.00
24.01	NON-OPERATING EXPENSES/INCOME	219,948	24.01
24.02	CONTRACT PHARMACY	376,766	24.02
24.50	COVID-19 PHE Funding	285,968	24.50
25.00	Total other income (sum of lines 6-24)	2,520,814	25.00
26.00	Total (line 5 plus line 25)	298,435	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)	298,435	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1304 | Component CCN: 15-8539 | Period: From 01/01/2022 To 12/31/2022 | Worksheet M-1 | Date/Time Prepared: 5/18/2023 12:26 pm

RHC I | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	466,551	0	466,551	0	466,551	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	538,746	0	538,746	-70,537	468,209	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	112,914	0	112,914	0	112,914	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	462,945	0	462,945	0	462,945	9.00
10.00	Subtotal (sum of lines 1 through 9)	1,581,156	0	1,581,156	-70,537	1,510,619	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	31,443	31,443	-19,883	11,560	15.00
16.00	Transportation (Health Care Staff)	0	142	142	0	142	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	31,585	31,585	-19,883	11,702	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,581,156	31,585	1,612,741	-90,420	1,522,321	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	40,058	40,058	0	40,058	29.00
30.00	Administrative Costs	281,811	106,081	387,892	0	387,892	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	281,811	146,139	427,950	0	427,950	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,862,967	177,724	2,040,691	-90,420	1,950,271	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1304 | Component CCN: 15-8539 | Period: From 01/01/2022 To 12/31/2022 | Worksheet M-1 | Date/Time Prepared: 5/18/2023 12:26 pm

RHC I | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
	FACILITY HEALTH CARE STAFF COSTS			
1.00	Physician	0	466,551	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	0	468,209	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	112,914	7.00
8.00	Laboratory Technician	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	462,945	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	1,510,619	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	11,560	15.00
16.00	Transportation (Health Care Staff)	0	142	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	11,702	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	1,522,321	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES			
23.00	Pharmacy	0	0	23.00
24.00	Dental	0	0	24.00
25.00	Optometry	0	0	25.00
25.01	Telehealth	0	0	25.01
25.02	Chronic Care Management	0	0	25.02
26.00	All other nonreimbursable costs	0	0	26.00
27.00	Nonallowable GME costs			27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	28.00
	FACILITY OVERHEAD			
29.00	Facility Costs	0	40,058	29.00
30.00	Administrative Costs	0	387,892	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	427,950	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	1,950,271	32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-1304 | Component CCN: 15-8539 | Period: From 01/01/2022 To 12/31/2022 | Worksheet M-2 | Date/Time Prepared: 5/18/2023 12:26 pm

RHC I | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	2.03	3,195	1	2		1.00
2.00	Physician Assistant	0.00	0	1	0		2.00
3.00	Nurse Practitioner	4.10	5,495	1	4		3.00
4.00	Subtotal (sum of lines 1 through 3)	6.13	8,690		6	8,690	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	1.60	570			570	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)	7.73	9,260			9,260	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)	1,522,321	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)	1,522,321	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)	427,950	14.00
15.00	Parent provider overhead allocated to facility (see instructions)	1,622,511	15.00
16.00	Total overhead (sum of lines 14 and 15)	2,050,461	16.00
17.00	Allowable GME overhead (see instructions)	0	17.00
18.00	Enter the amount from line 16	2,050,461	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)	2,050,461	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)	3,572,782	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 15-1304 Component CCN: 15-8539	Period: From 01/01/2022 To 12/31/2022	Worksheet M-3 Date/Time Prepared: 5/18/2023 12:26 pm
	Title XVIII	RHC I	Cost

			1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)		3,572,782	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)		8,421	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)		3,564,361	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		9,260	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)		0	5.00
6.00	Total adjusted visits (line 4 plus line 5)		9,260	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		384.92	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	167.95	8.00
9.00	Rate for Program covered visits (see instructions)	0.00	167.95	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	2,760	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	463,542	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	35	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	5,878	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	5,878	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	469,420	16.00
16.01	Total program charges (see instructions)(from contractor's records)		357,763	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		45,300	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		59,438	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.)		284,762	16.04
16.05	Total program cost (see instructions)	0	344,200	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		54,029	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		51,661	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		344,200	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)		344,200	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)		344,200	26.00
26.01	Sequestration adjustment (see instructions)		4,337	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		335,887	27.00
28.00	Tentative settlement (for contractor use only)		0	28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)		3,976	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: 15-1304 | Component CCN: 15-8539 | Period: From 01/01/2022 To 12/31/2022 | Worksheet M-4 | Date/Time Prepared: 5/18/2023 12:26 pm

Title XVIII | RHC I | Cost

		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	1,510,619	1,510,619	1,510,619	1,510,619	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000078	0.000144	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	118	218	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	2,146	1,106	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	2,264	1,324	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	1,522,321	1,522,321	1,522,321	1,522,321	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	2,050,461	2,050,461	2,050,461	2,050,461	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.001487	0.000870	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	3,049	1,784	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	5,313	3,108	0	0	10.00
11.00	Total number of injections/infusions (from your records)	19	35	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	279.63	88.80	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)		8,421	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

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 15-1304 Component CCN: 15-8539	Period: From 01/01/2022 To 12/31/2022	Worksheet M-5 Date/Time Prepared: 5/18/2023 12:26 pm
		RHC I	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		335,887	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)		335,887	4.00
	TO BE COMPLETED BY CONTRACTOR			
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
	Program to Provider			
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
	Provider to Program			
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		3,976	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		339,863	7.00

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