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: 15-1333	Period: From 01/01/2022 To 12/31/2022	Worksheet S Parts I-III Date/Time Prepared: 5/31/2023 8:41 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 5/31/2023 Time: 8:41 am
2. [ ] Manually prepared cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no.

Contractor use only

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

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

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by PUTNAM COUNTY HOSPITAL (15-1333) 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	Dennis Weatherford		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	Dennis Weatherford			2
3	Signatory Title	CEO			3
4	Date	05/31/2023 08:41:29 AM			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	631,425	943,952	0	0	1.00
2.00	SUBPROVIDER - IPF	0	0	0		0	2.00
3.00	SUBPROVIDER - IRF	0	0	0		0	3.00
5.00	SWING BED - SNF	0	51,117	0		0	5.00
6.00	SWING BED - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		-11,349		0	10.00
10.01	RURAL HEALTH CLINIC II	0		-1,141		0	10.01
10.02	RURAL HEALTH CLINIC III	0		7,936		0	10.02
200.00	TOTAL	0	682,542	939,398	0	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1333 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-2 Part I | Date/Time Prepared: 5/31/2023 8:41 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1542 SOUTH BLOOMINGTON ST	PO Box:			1.00
2.00	City: GREENCASTLE	State: IN	Zip Code: 46135-	County: PUTNAM	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	PUTNAM COUNTY HOSPITAL	151333	26900	1	12/31/2005	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	PUTNAM COUNTY HOSPITAL	15Z333	26900		12/31/2005	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	PPIM	158515	26900		02/23/2015	N	O	N	15.00
15.01	Hospital-Based Health Clinic - RHC II	FMC	158513	26900		02/25/2015	N	O	N	15.01
15.02	Hospital-Based Health Clinic - RHC III	NPFH	158514	26900		03/17/2015	N	O	N	15.02
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	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: 15-1333 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-2 Part I | Date/Time Prepared: 5/31/2023 8:41 am

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1333	Period: From 01/01/2022 To 12/31/2022	Worksheet S-2 Part I Date/Time Prepared: 5/31/2023 8:41 am

		V	XVIII	XIX	
		1.00	2.00	3.00	
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00

		NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
		1.00	2.00	3.00	
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment 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)				0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06

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

		1.00	
	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)		
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)	0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)	0.00	62.01
	Teaching Hospitals that Claim Residents in Nonprovider Settings		
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)	N	63.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1333 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-2 Part I Date/Time Prepared: 5/31/2023 8:41 am

				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
				1.00	2.00	3.00	
	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.						
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	64.00
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00
				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
				1.00	2.00	3.00	
	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010						
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	66.00
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	67.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1333 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-2 Part I Date/Time Prepared: 5/31/2023 8:41 am

				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: 15-1333 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-2 Part I Date/Time Prepared: 5/31/2023 8:41 am

		V	XIX	
		1.00	2.00	
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.06
	Rural Providers			
105.00	Does this hospital qualify as a CAH?	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)	Y		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.	Y	Y	Y	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1333 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-2 Part I | Date/Time Prepared: 5/31/2023 8:41 am

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	234,183	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: 15-1333 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-2 Part I Date/Time Prepared: 5/31/2023 8:41 am

					1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.				N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.				N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.				N	149.00
		Part A	Part B	Title V	Title XIX	
		1.00	2.00	3.00	4.00	
	Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)					
155.00	Hospital	N	N	N	N	155.00
156.00	Subprovider - IPF	N	N	N	N	156.00
157.00	Subprovider - IRF	N	N	N	N	157.00
158.00	SUBPROVIDER					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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1333 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-2 Part II | Date/Time Prepared: 5/31/2023 8:41 am

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

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

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

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	N		N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	04/04/2023	Y	04/04/2023	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: 15-1333 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-2 Part II Date/Time Prepared: 5/31/2023 8:41 am

		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00

		1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)		
	Capital Related Cost		
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions	N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.	N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions	Y	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	Y	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.	Y	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.	Y	35.00

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

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	SKANDER	NASSER	41.00
42.00	Enter the employer/company name of the cost report preparer.	BRADLEY ASSOCIATES		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-237-5500	SKANDERN@BRADLEYCPA.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-1333	Period: From 01/01/2022 To 12/31/2022	Worksheet S-2 Part II Date/Time Prepared: 5/31/2023 8:41 am

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1333 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-3 Part I | Date/Time Prepared: 5/31/2023 8:41 am

	Component	Worksheet A Line No.	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	19	6,935	33,384.00	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)		19	6,935	33,384.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	6	2,190	3,768.00	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	37,152.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	88.00				0	26.00
26.01	RURAL HEALTH CLINIC II	88.01				0	26.01
26.02	RURAL HEALTH CLINIC III	88.02				0	26.02
26.25	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: 15-1333 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-3 Part I | Date/Time Prepared: 5/31/2023 8:41 am

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	732	52	1,391			1.00
2.00	HMO and other (see instructions)	397	101				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	108	18	126			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	840	70	1,517			7.00
8.00	INTENSIVE CARE UNIT	68	0	157			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)	908	70	1,674	0.00	293.05	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	654	3,535	10,351	0.00	15.40	26.00
26.01	RURAL HEALTH CLINIC II	1,295	3,191	12,626	0.00	17.43	26.01
26.02	RURAL HEALTH CLINIC III	1,034	2,504	8,714	0.00	17.31	26.02
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	343.19	27.00
28.00	Observation Bed Days		0	709			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			10			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: 15-1333 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-3 Part I Date/Time Prepared: 5/31/2023 8:41 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	238	12	610	1.00
2.00	HMO and other (see instructions)			190	59		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	238	12	610	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0.00					26.00
26.01	RURAL HEALTH CLINIC II	0.00					26.01
26.02	RURAL HEALTH CLINIC III	0.00					26.02
26.25	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: 15-1333 | Component CCN: 15-8515 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-8 | Date/Time Prepared: 5/31/2023 8:41 am

RHC I | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			1542 S. BLOOMINGTON STREET		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	GREENCASTLE		IN	46135	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	CLINIC			07:00	17:00	07:00	11.00
					1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?				Y		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.				N	0	13.00
				Provider name		CCN	
				1.00		2.00	
14.00	RHC/FQHC name, CCN						14.00

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

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

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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-1333 | Component CCN: 15-8515 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-8 | Date/Time Prepared: 5/31/2023 8:41 am

RHC I | Cost

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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-1333 | Component CCN: 15-8513 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-8 | Date/Time Prepared: 5/31/2023 8:41 am

RHC II | Cost

					1.00	
	Clinic Address and Identification					
1.00	Street			51 E. MARKET STREET		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	CLOVERDALE		IN	46120	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	CLINIC			07:00	17:30	07:00	11.00

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

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

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

			County				
			4.00				
2.00	City, State, ZIP Code, County		PUTNAM				2.00
		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC	17:30	07:00	17:30	07:00	17:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 15-1333
Component CCN: 15-8513

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

Worksheet S-8
Date/Time Prepared:
5/31/2023 8:41 am

RHC II | Cost

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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-1333 | Component CCN: 15-8514 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-8 | Date/Time Prepared: 5/31/2023 8:41 am

RHC III | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			440 E. PAT RADY WAY		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	BAINBRIDGE		IN	46105	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	CLINIC			08:00	17:00	07:00	11.00

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

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

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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-1333 | Component CCN: 15-8514 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-8 | Date/Time Prepared: 5/31/2023 8:41 am

RHC III | Cost

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

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-1333 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-10 | Date/Time Prepared: 5/31/2023 8:41 am

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.407195	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	3,671,979	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	N	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	1,092,566	5.00
6.00	Medicaid charges	22,949,866	6.00
7.00	Medicaid cost (line 1 times line 6)	9,345,071	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)	4,580,526	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)	4,580,526	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	635,561	0	635,561	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	258,797	0	258,797	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)	258,797	0	258,797	23.00

		1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	3,302,792	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	587,188	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	903,367	27.01
28.00	Non-Medicare bad debt expense (see instructions)	2,399,425	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	1,293,213	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,552,010	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	6,132,536	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1333 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A | Date/Time Prepared: 5/31/2023 8:41 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		2,596,953	2,596,953	84,771	2,681,724	1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	191,174	6,315,016	6,506,190	0	6,506,190	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,176,916	6,186,204	9,363,120	-84,771	9,278,349	5.00
7.00	00700	OPERATION OF PLANT	356,978	1,284,378	1,641,356	0	1,641,356	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	31,654	225,010	256,664	0	256,664	8.00
9.00	00900	HOUSEKEEPING	426,531	118,268	544,799	0	544,799	9.00
10.00	01000	DIETARY	496,569	702,873	1,199,442	-840,416	359,026	10.00
11.00	01100	CAFETERIA	0	0	0	840,416	840,416	11.00
13.00	01300	NURSING ADMINISTRATION	185,811	46,271	232,082	0	232,082	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	290,310	168,727	459,037	0	459,037	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
17.01	01701	UTILIZATION REVIEW	118,464	7,984	126,448	0	126,448	17.01
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,307,829	152,243	2,460,072	-30,796	2,429,276	30.00
31.00	03100	INTENSIVE CARE UNIT	481,123	416,105	897,228	-29,458	867,770	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	718,921	901,066	1,619,987	-409,523	1,210,464	50.00
51.00	05100	RECOVERY ROOM	113,477	29,540	143,017	0	143,017	51.00
53.00	05300	ANESTHESIOLOGY	869,541	40,330	909,871	0	909,871	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,279,752	385,772	1,665,524	0	1,665,524	54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	195,631	195,631	0	195,631	54.01
54.02	03480	ONCOLOGY	396,606	5,087,522	5,484,128	0	5,484,128	54.02
57.00	05700	CT SCAN	213,913	371,929	585,842	0	585,842	57.00
60.00	06000	LABORATORY	922,887	1,801,547	2,724,434	0	2,724,434	60.00
65.00	06500	RESPIRATORY THERAPY	506,139	77,461	583,600	0	583,600	65.00
66.00	06600	PHYSICAL THERAPY	0	525,254	525,254	0	525,254	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	113,729	113,729	0	113,729	67.00
68.00	06800	SPEECH PATHOLOGY	0	36,708	36,708	0	36,708	68.00
69.00	06900	ELECTROCARDIOLOGY	86,056	53,770	139,826	0	139,826	69.00
69.01	06901	CARDIAC REHAB	267,463	10,003	277,466	0	277,466	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	469,781	469,781	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	351,758	1,040,875	1,392,633	0	1,392,633	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,431,753	268,822	1,700,575	-91,229	1,609,346	88.00
88.01	08801	RURAL HEALTH CLINIC II	1,429,904	257,606	1,687,510	31,503	1,719,013	88.01
88.02	08802	RURAL HEALTH CLINIC III	1,365,980	279,073	1,645,053	59,726	1,704,779	88.02
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	RHEUMATOLOGY	428,783	29,281	458,064	0	458,064	90.01
91.00	09100	EMERGENCY	3,334,763	1,577,846	4,912,609	-4	4,912,605	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	21,781,055	31,303,797	53,084,852	0	53,084,852	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	4,588,712	1,004,038	5,592,750	0	5,592,750	192.00
192.01	19201	JOHNSON/NICHOLS WIC	266,077	93,214	359,291	0	359,291	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	VACANT SPACE	0	0	0	0	0	194.00
194.01	07951	BOARD OF HEALTH	0	0	0	0	0	194.01
200.00		TOTAL (SUM OF LINES 118 through 199)	26,635,844	32,401,049	59,036,893	0	59,036,893	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1333 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A | Date/Time Prepared: 5/31/2023 8:41 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	-601,894	2,079,830		1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-2,846	6,503,344		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-2,924,525	6,353,824		5.00
7.00	00700	OPERATION OF PLANT	-9,327	1,632,029		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	256,664		8.00
9.00	00900	HOUSEKEEPING	0	544,799		9.00
10.00	01000	DIETARY	0	359,026		10.00
11.00	01100	CAFETERIA	-87,987	752,429		11.00
13.00	01300	NURSING ADMINISTRATION	-1,251	230,831		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-131	458,906		16.00
17.00	01700	SOCIAL SERVICE	0	0		17.00
17.01	01701	UTILIZATION REVIEW	0	126,448		17.01
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-1,351,702	1,077,574		30.00
31.00	03100	INTENSIVE CARE UNIT	0	867,770		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-790	1,209,674		50.00
51.00	05100	RECOVERY ROOM	0	143,017		51.00
53.00	05300	ANESTHESIOLOGY	-717,596	192,275		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,665,524		54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	195,631		54.01
54.02	03480	ONCOLOGY	-2,814	5,481,314		54.02
57.00	05700	CT SCAN	0	585,842		57.00
60.00	06000	LABORATORY	0	2,724,434		60.00
65.00	06500	RESPIRATORY THERAPY	0	583,600		65.00
66.00	06600	PHYSICAL THERAPY	0	525,254		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	113,729		67.00
68.00	06800	SPEECH PATHOLOGY	0	36,708		68.00
69.00	06900	ELECTROCARDIOLOGY	0	139,826		69.00
69.01	06901	CARDIAC REHAB	-569	276,897		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	469,781		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-26,441	1,366,192		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	-131	1,609,215		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	1,719,013		88.01
88.02	08802	RURAL HEALTH CLINIC III	-3,200	1,701,579		88.02
90.00	09000	CLINIC	0	0		90.00
90.01	09001	RHEUMATOLOGY	-274,956	183,108		90.01
91.00	09100	EMERGENCY	-2,755,599	2,157,006		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-8,761,759	44,323,093		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	5,592,750		192.00
192.01	19201	JOHNSON/NICHOLS WIC	0	359,291		192.01
193.00	19300	NONPAID WORKERS	0	0		193.00
194.00	07950	VACANT SPACE	0	0		194.00
194.01	07951	BOARD OF HEALTH	0	0		194.01
200.00		TOTAL (SUM OF LINES 118 through 199)	-8,761,759	50,275,134		200.00

RECLASSIFICATIONS | Provider CCN: 15-1333 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-6 | Date/Time Prepared: 5/31/2023 8:41 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - Cafeteria Reclass					
1.00	CAFETERIA	11.00	347,932	492,484		1.00
	TOTALS		347,932	492,484		
	B - Insurance Reclass					
1.00	CAP REL COSTS-BLDG & FIXT	1.00		84,771		1.00
2.00						2.00
			0	84,771		
	C - Implant Reclass					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	469,781		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
	TOTALS		0	469,781		
	D - BHC Dept. 985 Reclass					
1.00	RURAL HEALTH CLINIC II	88.01	19,559	1,636		1.00
2.00	RURAL HEALTH CLINIC III	88.02	22,938	1,919		2.00
			42,497	3,555		
	E - BHC Dept. 980 Reclass					
1.00	RURAL HEALTH CLINIC II	88.01	5,457	631		1.00
2.00	RURAL HEALTH CLINIC III	88.02	18,459	2,135		2.00
	TOTALS		23,916	2,766		
	F - BHC Dept. 982 Reclass					
1.00	RURAL HEALTH CLINIC II	88.01	4,075	145		1.00
2.00	RURAL HEALTH CLINIC III	88.02	13,784	491		2.00
	TOTALS		17,859	636		
500.00	Grand Total: Increases		432,204	1,053,993		500.00

RECLASSIFICATIONS | Provider CCN: 15-1333 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-6 | Date/Time Prepared: 5/31/2023 8:41 am

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - Cafeteria Reclass						
1.00	DIETARY	10.00	347,932	492,484	0		1.00
	TOTALS		347,932	492,484			
	B - Insurance Reclass						
1.00	ADMINISTRATIVE & GENERAL	5.00		84,771	12		1.00
2.00					12		2.00
			0	84,771			
	C - Implant Reclass						
1.00	ADULTS & PEDIATRICS	30.00	0	30,796	0		1.00
2.00	INTENSIVE CARE UNIT	31.00	0	29,458	0		2.00
3.00	OPERATING ROOM	50.00	0	409,523	0		3.00
4.00	EMERGENCY	91.00	0	4	0		4.00
	TOTALS		0	469,781			
	D - BHC Dept. 985 Reclass						
1.00	RURAL HEALTH CLINIC	88.00	42,497	3,555			1.00
2.00							2.00
			42,497	3,555			
	E - BHC Dept. 980 Reclass						
1.00	RURAL HEALTH CLINIC	88.00	23,916	2,766	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		23,916	2,766			
	F - BHC Dept. 982 Reclass						
1.00	RURAL HEALTH CLINIC	88.00	17,859	636	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		17,859	636			
500.00	Grand Total: Decreases		432,204	1,053,993			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1333 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-7 Part I | Date/Time Prepared: 5/31/2023 8:41 am

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	260,501	0	0	0	0	1.00
2.00	Land Improvements	404,895	0	0	0	12,999	2.00
3.00	Buildings and Fixtures	35,718,433	44,051	0	44,051	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	25,347,938	1,515,306	0	1,515,306	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	61,731,767	1,559,357	0	1,559,357	12,999	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	61,731,767	1,559,357	0	1,559,357	12,999	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	260,501	0	1.00
2.00	Land Improvements	391,896	0	2.00
3.00	Buildings and Fixtures	35,762,484	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	26,863,244	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	63,278,125	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	63,278,125	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1333 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-7 Part II Date/Time Prepared: 5/31/2023 8:41 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	1,812,307	537,166	217,576	0	29,904	1.00
3.00	Total (sum of lines 1-2)	1,812,307	537,166	217,576	0	29,904	3.00

	Cost Center Description	SUMMARY OF CAPITAL			
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)		
		14.00	15.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2				
1.00	CAP REL COSTS-BLDG & FIXT	0	2,596,953		1.00
3.00	Total (sum of lines 1-2)	0	2,596,953		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1333 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-7 Part III Date/Time Prepared: 5/31/2023 8:41 am

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	61,718,768	0	61,718,768	1.000000	0	1.00
3.00	Total (sum of lines 1-2)	61,718,768	0	61,718,768	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1,812,307	-1	1.00
3.00	Total (sum of lines 1-2)	0	0	0	1,812,307	-1	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	152,849	84,771	29,904	0	2,079,830	1.00
3.00	Total (sum of lines 1-2)	152,849	84,771	29,904	0	2,079,830	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1333 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-8 | Date/Time Prepared: 5/31/2023 8:41 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-64,727	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	*** Cost Center Deleted ***	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)	B	-4	ADMINISTRATIVE & GENERAL	5.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)	B	-12,154	ADMINISTRATIVE & GENERAL	5.00	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)	A	-9,327	OPERATION OF PLANT	7.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-4,735,739			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-56,351	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients	B	-131	MEDICAL RECORDS & LIBRARY	16.00	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 - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	*** Cost Center Deleted ***	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	CBO Misc. Revenue	B	-28,282	ADMINISTRATIVE & GENERAL	5.00	0	33.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1333 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-8 | Date/Time Prepared: 5/31/2023 8:41 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.01	Cardiac Rehab Other Misc. Income	B	-57	CARDIAC REHAB	69.01	0	33.01
33.02	Pharmacy Rebates & Misc. Income	B	-11,969	DRUGS CHARGED TO PATIENTS	73.00	0	33.02
33.03	Admin Other Misc. Income	B	-10,087	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04	Nursing Admin Other Misc. Income	B	-1,251	NURSING ADMINISTRATION	13.00	0	33.04
33.05	340B Program Offset	A	-14,472	DRUGS CHARGED TO PATIENTS	73.00	0	33.05
33.06	Advertising	A	-168,871	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07	Advertising	A	-790	OPERATING ROOM	50.00	0	33.07
33.08	Advertising	A	-2,814	ONCOLOGY	54.02	0	33.08
33.09	Advertising	A	-512	CARDIAC REHAB	69.01	0	33.09
33.10	Advertising	A	-131	RURAL HEALTH CLINIC	88.00	0	33.10
33.11	Advertising	A	-3,200	RURAL HEALTH CLINIC III	88.02	0	33.11
33.12	Advertising	A	-1,178	RHEUMATOLOGY	90.01	0	33.12
33.13	Intercompany Rent	A	-537,167	CAP REL COSTS-BLDG & FIXT	1.00	10	33.13
33.14	Community Relations FICA	A	-2,846	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.14
33.15	Community Relations	A	-193,797	ADMINISTRATIVE & GENERAL	5.00	0	33.15
33.16	Lobbying	A	-1,884	ADMINISTRATIVE & GENERAL	5.00	0	33.16
33.17	Physician Recruitment	A	-14,000	ADULTS & PEDIATRICS	30.00	0	33.17
33.18	HAF Expense	A	-2,509,446	ADMINISTRATIVE & GENERAL	5.00	0	33.18
33.19	Non-Allowable CRNA	A	-348,936	ANESTHESIOLOGY	53.00	0	33.19
33.20	NON-ALLOWABLE INTEREST EXPENSE	A	-31,636	CAFETERIA	11.00	0	33.20
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-8,761,759				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: 15-1333 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-8-2 | Date/Time Prepared: 5/31/2023 8:41 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	1,337,702	1,337,702	0	0	0	1.00
2.00	53.00	ANESTHESIOLOGY	460,541	368,660	91,881	0	0	2.00
3.00	90.01	RHEUMATOLOGY	273,778	273,778	0	0	0	3.00
4.00	91.00	EMERGENCY	3,089,819	2,755,599	334,220	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			5,161,840	4,735,739	426,101		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	53.00	ANESTHESIOLOGY	0	0	0	0	0	2.00
3.00	90.01	RHEUMATOLOGY	0	0	0	0	0	3.00
4.00	91.00	EMERGENCY	0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	1,337,702		1.00
2.00	53.00	ANESTHESIOLOGY	0	0	0	368,660		2.00
3.00	90.01	RHEUMATOLOGY	0	0	0	273,778		3.00
4.00	91.00	EMERGENCY	0	0	0	2,755,599		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	4,735,739		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 15-1333 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-8-3 Parts I-VI Date/Time Prepared: 5/31/2023 8:41 am

Physical Therapy — Cost

						1.00	
	PART I - GENERAL INFORMATION						
1.00	Total number of weeks worked (excluding aides) (see instructions)					52	1.00
2.00	Line 1 multiplied by 15 hours per week					780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					299	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					194	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					9.57	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	4,146.02	1,672.92	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	92.74	69.56	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	46.37	46.37	34.78			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION						
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					384,502	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)					116,368	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					500,870	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					500,870	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.						
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					0	22.00
23.00	Total salary equivalency (see instructions)					500,870	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE						
	Standard Travel Allowance						
24.00	Therapists (line 3 times column 2, line 11)					13,865	24.00
25.00	Assistants (line 4 times column 3, line 11)					6,747	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					20,612	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					4,718	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					25,330	28.00
	Optional Travel Allowance and Optional Travel Expense						
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					25,330	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE						
	Standard Travel Expense						
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
	Optional Travel Allowance and Optional Travel Expense						
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.						
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 15-1333 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 5/31/2023 8:41 am

Physical Therapy — Cost

						1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	92.74	69.56	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00		
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT			
57.00	Salary equivalency amount (from line 23)	500,870		57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	25,330		58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0		59.00
60.00	Overtime allowance (from column 5, line 56)	0		60.00
61.00	Equipment cost (see instructions)	0		61.00
62.00	Supplies (see instructions)	0		62.00
63.00	Total allowance (sum of lines 57-62)	526,200		63.00
64.00	Total cost of outside supplier services (from your records)	481,181		64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0		65.00
	LINE 33 CALCULATION			
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	20,612		100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	4,718		100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	25,330		100.02
	LINE 34 CALCULATION			
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	4,718		101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0		101.01
101.02	Line 34 = sum of lines 27 and 31	4,718		101.02
	LINE 35 CALCULATION			
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0		102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0		102.01
102.02	Line 35 = sum of lines 31 and 32	0		102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 15-1333 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-8-3 Parts I-VI Date/Time Prepared: 5/31/2023 8:41 am

		Occupational Therapy	Cost
			1.00
	PART I - GENERAL INFORMATION		
1.00	Total number of weeks worked (excluding aides) (see instructions)	51	1.00
2.00	Line 1 multiplied by 15 hours per week	765	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)	250	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)	0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)	0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)	0	6.00
7.00	Standard travel expense rate	9.57	7.00
8.00	Optional travel expense rate per mile	0.00	8.00

		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	1,529.96	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	87.92	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	43.96	43.96	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01

		1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION		
14.00	Supervisors (column 1, line 9 times column 1, line 10)	0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)	134,514	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)	0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)	134,514	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)	0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)	0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)	134,514	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.		
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)	0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)	0	22.00
23.00	Total salary equivalency (see instructions)	134,514	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE		
	Standard Travel Allowance		
24.00	Therapists (line 3 times column 2, line 11)	10,990	24.00
25.00	Assistants (line 4 times column 3, line 11)	0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)	10,990	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)	2,393	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)	13,383	28.00
	Optional Travel Allowance and Optional Travel Expense		
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)	0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)	0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)	0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)	0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)	13,383	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)	0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)	0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE		
	Standard Travel Expense		
36.00	Therapists (line 5 times column 2, line 11)	0	36.00
37.00	Assistants (line 6 times column 3, line 11)	0	37.00
38.00	Subtotal (sum of lines 36 and 37)	0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)	0	39.00
	Optional Travel Allowance and Optional Travel Expense		
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)	0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)	0	41.00
42.00	Subtotal (sum of lines 40 and 41)	0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)	0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.		
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)	0	44.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 15-1333 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-8-3 Parts I-VI Date/Time Prepared: 5/31/2023 8:41 am

		Occupational Therapy	Cost	
			1.00	
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)		0	45.00
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)		0	46.00

		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	87.92	0.00	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT		
57.00	Salary equivalency amount (from line 23)	134,514	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	13,383	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0	59.00
60.00	Overtime allowance (from column 5, line 56)	0	60.00
61.00	Equipment cost (see instructions)	0	61.00
62.00	Supplies (see instructions)	0	62.00
63.00	Total allowance (sum of lines 57-62)	147,897	63.00
64.00	Total cost of outside supplier services (from your records)	113,729	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0	65.00
	LINE 33 CALCULATION		
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	10,990	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	2,393	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	13,383	100.02
	LINE 34 CALCULATION		
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	2,393	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	101.01
101.02	Line 34 = sum of lines 27 and 31	2,393	101.02
	LINE 35 CALCULATION		
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0	102.01
102.02	Line 35 = sum of lines 31 and 32	0	102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 15-1333 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-8-3 Parts I-VI Date/Time Prepared: 5/31/2023 8:41 am

Speech Pathology | Cost

						1.00	
	PART I - GENERAL INFORMATION						
1.00	Total number of weeks worked (excluding aides) (see instructions)					51	1.00
2.00	Line 1 multiplied by 15 hours per week					765	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					127	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					9.57	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	648.34	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	84.50	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	42.25	42.25	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION						
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					54,785	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)					0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					54,785	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					54,785	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.						
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					84.50	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					64,643	22.00
23.00	Total salary equivalency (see instructions)					64,643	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE						
	Standard Travel Allowance						
24.00	Therapists (line 3 times column 2, line 11)					5,366	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					5,366	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					1,215	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					6,581	28.00
	Optional Travel Allowance and Optional Travel Expense						
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					6,581	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE						
	Standard Travel Expense						
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
	Optional Travel Allowance and Optional Travel Expense						
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.						
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 15-1333 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 5/31/2023 8:41 am

Speech Pathology | Cost

						1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	84.50	0.00	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00		
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT			
57.00	Salary equivalency amount (from line 23)	64,643		57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	6,581		58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0		59.00
60.00	Overtime allowance (from column 5, line 56)	0		60.00
61.00	Equipment cost (see instructions)	0		61.00
62.00	Supplies (see instructions)	0		62.00
63.00	Total allowance (sum of lines 57-62)	71,224		63.00
64.00	Total cost of outside supplier services (from your records)	36,708		64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0		65.00
	LINE 33 CALCULATION			
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	5,366		100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	1,215		100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	6,581		100.02
	LINE 34 CALCULATION			
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	1,215		101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0		101.01
101.02	Line 34 = sum of lines 27 and 31	1,215		101.02
	LINE 35 CALCULATION			
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0		102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0		102.01
102.02	Line 35 = sum of lines 31 and 32	0		102.02

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1333 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part I Date/Time Prepared: 5/31/2023 8:41 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
			0	1.00	4.00	4A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	2,079,830	2,079,830				1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	6,503,344	2,827	6,506,171			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	6,353,824	270,277	781,617	7,405,718	7,405,718	5.00
7.00	00700	OPERATION OF PLANT	1,632,029	163,018	87,827	1,882,874	325,268	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	256,664	12,490	7,788	276,942	47,842	8.00
9.00	00900	HOUSEKEEPING	544,799	5,210	104,939	654,948	113,143	9.00
10.00	01000	DIETARY	359,026	62,617	36,569	458,212	79,157	10.00
11.00	01100	CAFETERIA	752,429	29,636	85,602	867,667	149,890	11.00
13.00	01300	NURSING ADMINISTRATION	230,831	12,287	45,715	288,833	49,896	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	458,906	73,019	71,425	603,350	104,229	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
17.01	01701	UTILIZATION REVIEW	126,448	6,153	29,146	161,747	27,942	17.01
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,077,574	113,649	567,795	1,759,018	303,872	30.00
31.00	03100	INTENSIVE CARE UNIT	867,770	52,492	118,371	1,038,633	179,425	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,209,674	151,157	176,876	1,537,707	265,640	50.00
51.00	05100	RECOVERY ROOM	143,017	42,404	27,919	213,340	36,855	51.00
53.00	05300	ANESTHESIOLOGY	192,275	0	213,933	406,208	70,173	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,665,524	56,002	314,857	2,036,383	351,787	54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	195,631	2,587	0	198,218	34,242	54.01
54.02	03480	ONCOLOGY	5,481,314	89,741	97,577	5,668,632	979,262	54.02
57.00	05700	CT SCAN	585,842	24,389	52,629	662,860	114,510	57.00
60.00	06000	LABORATORY	2,724,434	46,376	227,058	2,997,868	517,885	60.00
65.00	06500	RESPIRATORY THERAPY	583,600	12,934	124,525	721,059	124,564	65.00
66.00	06600	PHYSICAL THERAPY	525,254	31,484	0	556,738	96,177	66.00
67.00	06700	OCCUPATIONAL THERAPY	113,729	0	0	113,729	19,647	67.00
68.00	06800	SPEECH PATHOLOGY	36,708	0	0	36,708	6,341	68.00
69.00	06900	ELECTROCARDIOLOGY	139,826	1,848	21,172	162,846	28,132	69.00
69.01	06901	CARDIAC REHAB	276,897	55,873	65,804	398,574	68,854	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	469,781	0	0	469,781	81,155	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,366,192	16,555	86,543	1,469,290	253,821	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,609,215	100,438	331,521	2,041,174	352,615	88.00
88.01	08801	RURAL HEALTH CLINIC II	1,719,013	120,097	358,957	2,198,067	379,718	88.01
88.02	08802	RURAL HEALTH CLINIC III	1,701,579	120,097	349,648	2,171,324	375,098	88.02
90.00	09000	CLINIC	0	2,993	0	2,993	517	90.00
90.01	09001	RHEUMATOLOGY	183,108	8,702	105,493	297,303	51,359	90.01
91.00	09100	EMERGENCY	2,157,006	107,275	820,452	3,084,733	532,891	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	44,323,093	1,794,627	5,311,758	42,843,477	6,121,907	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	8,813	0	8,813	1,522	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	5,592,750	263,586	1,128,950	6,985,286	1,206,700	192.00
192.01	19201	JOHNSON/NICHOLS WIC	359,291	0	65,463	424,754	73,377	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	VACANT SPACE	0	0	0	0	0	194.00
194.01	07951	BOARD OF HEALTH	0	12,804	0	12,804	2,212	194.01
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)	50,275,134	2,079,830	6,506,171	50,275,134	7,405,718	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1333 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part I Date/Time Prepared: 5/31/2023 8:41 am

		Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	2,208,142					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	16,779	341,563				8.00
9.00	00900	HOUSEKEEPING	7,000	1,917	777,008			9.00
10.00	01000	DIETARY	84,119	1,415	37,616	660,519		10.00
11.00	01100	CAFETERIA	39,813	0	17,804	0	1,075,174	11.00
13.00	01300	NURSING ADMINISTRATION	16,506	0	7,381	0	9,650	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	98,093	0	43,865	0	46,059	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
17.01	01701	UTILIZATION REVIEW	8,265	0	3,696	0	10,758	17.01
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	152,675	74,304	68,273	593,528	137,774	30.00
31.00	03100	INTENSIVE CARE UNIT	70,517	57,377	31,534	66,991	42,276	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	203,062	48,486	92,603	0	137,839	50.00
51.00	05100	RECOVERY ROOM	56,965	5,253	25,473	0	17,955	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	20,952	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	75,233	25,552	33,643	0	145,460	54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	3,475	0	1,554	0	0	54.01
54.02	03480	ONCOLOGY	120,556	10,980	53,910	0	39,625	54.02
57.00	05700	CT SCAN	32,764	0	14,651	0	21,307	57.00
60.00	06000	LABORATORY	62,301	0	27,860	0	123,305	60.00
65.00	06500	RESPIRATORY THERAPY	17,375	0	7,770	0	45,567	65.00
66.00	06600	PHYSICAL THERAPY	42,295	9,432	18,914	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	2,482	0	1,110	0	8,039	69.00
69.01	06901	CARDIAC REHAB	75,059	0	33,565	0	22,269	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	22,240	0	9,945	0	30,523	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	134,928	7,646	60,337	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	161,338	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	161,338	0	0	0	0	88.02
90.00	09000	CLINIC	4,021	0	0	0	0	90.00
90.01	09001	RHEUMATOLOGY	11,691	0	5,228	0	29,425	90.01
91.00	09100	EMERGENCY	144,112	83,168	64,444	0	157,127	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,825,002	325,530	661,176	660,519	1,045,910	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	11,840	0	5,294	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	354,099	16,033	102,846	0	0	192.00
192.01	19201	JOHNSON/NICHOLS WIC	0	0	0	0	29,264	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	VACANT SPACE	0	0	0	0	0	194.00
194.01	07951	BOARD OF HEALTH	17,201	0	7,692	0	0	194.01
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)	2,208,142	341,563	777,008	660,519	1,075,174	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1333 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part I Date/Time Prepared: 5/31/2023 8:41 am

		Cost Center Description	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	UTILIZATION REVIEW	Subtotal	
			13.00	16.00	17.00	17.01	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	372,266					13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	895,596				16.00
17.00	01700	SOCIAL SERVICE	0	0	0			17.00
17.01	01701	UTILIZATION REVIEW	0	0	0	212,408		17.01
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	152,111	325,219	0	190,865	3,757,639	30.00
31.00	03100	INTENSIVE CARE UNIT	46,675	0	0	21,543	1,554,971	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	277,238	0	0	2,562,575	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	355,841	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	497,333	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	2,668,058	54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	0	0	0	237,489	54.01
54.02	03480	ONCOLOGY	0	0	0	0	6,872,965	54.02
57.00	05700	CT SCAN	0	0	0	0	846,092	57.00
60.00	06000	LABORATORY	0	0	0	0	3,729,219	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	916,335	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	723,556	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	133,376	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	43,049	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	202,609	69.00
69.01	06901	CARDIAC REHAB	0	0	0	0	598,321	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	550,936	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,785,819	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	2,596,700	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	2,739,123	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	2,707,760	88.02
90.00	09000	CLINIC	0	0	0	0	7,531	90.00
90.01	09001	RHEUMATOLOGY	0	0	0	0	395,006	90.01
91.00	09100	EMERGENCY	173,480	293,139	0	0	4,533,094	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	372,266	895,596	0	212,408	41,015,397	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	27,469	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	8,664,964	192.00
192.01	19201	JOHNSON/NICHOLS WIC	0	0	0	0	527,395	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	VACANT SPACE	0	0	0	0	0	194.00
194.01	07951	BOARD OF HEALTH	0	0	0	0	39,909	194.01
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)	372,266	895,596	0	212,408	50,275,134	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1333 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part I | Date/Time Prepared: 5/31/2023 8:41 am

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE				17.00
17.01	01701	UTILIZATION REVIEW				17.01
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	3,757,639		30.00
31.00	03100	INTENSIVE CARE UNIT	0	1,554,971		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	2,562,575		50.00
51.00	05100	RECOVERY ROOM	0	355,841		51.00
53.00	05300	ANESTHESIOLOGY	0	497,333		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,668,058		54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	237,489		54.01
54.02	03480	ONCOLOGY	0	6,872,965		54.02
57.00	05700	CT SCAN	0	846,092		57.00
60.00	06000	LABORATORY	0	3,729,219		60.00
65.00	06500	RESPIRATORY THERAPY	0	916,335		65.00
66.00	06600	PHYSICAL THERAPY	0	723,556		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	133,376		67.00
68.00	06800	SPEECH PATHOLOGY	0	43,049		68.00
69.00	06900	ELECTROCARDIOLOGY	0	202,609		69.00
69.01	06901	CARDIAC REHAB	0	598,321		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	550,936		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,785,819		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	2,596,700		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	2,739,123		88.01
88.02	08802	RURAL HEALTH CLINIC III	0	2,707,760		88.02
90.00	09000	CLINIC	0	7,531		90.00
90.01	09001	RHEUMATOLOGY	0	395,006		90.01
91.00	09100	EMERGENCY	0	4,533,094		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0			92.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	41,015,397		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	27,469		190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	8,664,964		192.00
192.01	19201	JOHNSON/NICHOLS WIC	0	527,395		192.01
193.00	19300	NONPAID WORKERS	0	0		193.00
194.00	07950	VACANT SPACE	0	0		194.00
194.01	07951	BOARD OF HEALTH	0	39,909		194.01
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	50,275,134		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1333 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part II Date/Time Prepared: 5/31/2023 8:41 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	
			0	1.00	2A	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	2,827	2,827	2,827		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	270,277	270,277	340	270,617	5.00
7.00	00700	OPERATION OF PLANT	0	163,018	163,018	38	11,887	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	12,490	12,490	3	1,748	8.00
9.00	00900	HOUSEKEEPING	0	5,210	5,210	46	4,135	9.00
10.00	01000	DIETARY	0	62,617	62,617	16	2,893	10.00
11.00	01100	CAFETERIA	0	29,636	29,636	37	5,478	11.00
13.00	01300	NURSING ADMINISTRATION	0	12,287	12,287	20	1,823	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	73,019	73,019	31	3,809	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
17.01	01701	UTILIZATION REVIEW	0	6,153	6,153	13	1,021	17.01
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	113,649	113,649	247	11,105	30.00
31.00	03100	INTENSIVE CARE UNIT	0	52,492	52,492	51	6,557	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	151,157	151,157	77	9,708	50.00
51.00	05100	RECOVERY ROOM	0	42,404	42,404	12	1,347	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	93	2,564	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	56,002	56,002	137	12,856	54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	2,587	2,587	0	1,251	54.01
54.02	03480	ONCOLOGY	0	89,741	89,741	42	35,786	54.02
57.00	05700	CT SCAN	0	24,389	24,389	23	4,185	57.00
60.00	06000	LABORATORY	0	46,376	46,376	99	18,926	60.00
65.00	06500	RESPIRATORY THERAPY	0	12,934	12,934	54	4,552	65.00
66.00	06600	PHYSICAL THERAPY	0	31,484	31,484	0	3,515	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	718	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	232	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,848	1,848	9	1,028	69.00
69.01	06901	CARDIAC REHAB	0	55,873	55,873	29	2,516	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	2,966	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	16,555	16,555	38	9,276	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	100,438	100,438	144	12,886	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	120,097	120,097	156	13,876	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	120,097	120,097	152	13,708	88.02
90.00	09000	CLINIC	0	2,993	2,993	0	19	90.00
90.01	09001	RHEUMATOLOGY	0	8,702	8,702	46	1,877	90.01
91.00	09100	EMERGENCY	0	107,275	107,275	357	19,474	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0			92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	1,794,627	1,794,627	2,310	223,722	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	8,813	8,813	0	56	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	263,586	263,586	489	44,077	192.00
192.01	19201	JOHNSON/NICHOLS WIC	0	0	0	28	2,681	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	VACANT SPACE	0	0	0	0	0	194.00
194.01	07951	BOARD OF HEALTH	0	12,804	12,804	0	81	194.01
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	2,079,830	2,079,830	2,827	270,617	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1333 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part II Date/Time Prepared: 5/31/2023 8:41 am

		Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	174,943					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,329	15,570				8.00
9.00	00900	HOUSEKEEPING	555	87	10,033			9.00
10.00	01000	DIETARY	6,664	65	486	72,741		10.00
11.00	01100	CAFETERIA	3,154	0	230	0	38,535	11.00
13.00	01300	NURSING ADMINISTRATION	1,308	0	95	0	346	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	7,772	0	566	0	1,651	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
17.01	01701	UTILIZATION REVIEW	655	0	48	0	386	17.01
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	12,096	3,387	882	65,364	4,938	30.00
31.00	03100	INTENSIVE CARE UNIT	5,587	2,616	407	7,377	1,515	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	16,088	2,210	1,196	0	4,940	50.00
51.00	05100	RECOVERY ROOM	4,513	239	329	0	644	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	751	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,960	1,165	434	0	5,213	54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	275	0	20	0	0	54.01
54.02	03480	ONCOLOGY	9,551	501	696	0	1,420	54.02
57.00	05700	CT SCAN	2,596	0	189	0	764	57.00
60.00	06000	LABORATORY	4,936	0	360	0	4,419	60.00
65.00	06500	RESPIRATORY THERAPY	1,377	0	100	0	1,633	65.00
66.00	06600	PHYSICAL THERAPY	3,351	430	244	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	197	0	14	0	288	69.00
69.01	06901	CARDIAC REHAB	5,947	0	433	0	798	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,762	0	128	0	1,094	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	10,690	349	779	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	12,782	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	12,782	0	0	0	0	88.02
90.00	09000	CLINIC	319	0	0	0	0	90.00
90.01	09001	RHEUMATOLOGY	926	0	68	0	1,055	90.01
91.00	09100	EMERGENCY	11,417	3,790	832	0	5,631	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	144,589	14,839	8,536	72,741	37,486	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	938	0	68	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	28,053	731	1,330	0	0	192.00
192.01	19201	JOHNSON/NICHOLS WIC	0	0	0	0	1,049	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	VACANT SPACE	0	0	0	0	0	194.00
194.01	07951	BOARD OF HEALTH	1,363	0	99	0	0	194.01
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)	174,943	15,570	10,033	72,741	38,535	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1333 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part II Date/Time Prepared: 5/31/2023 8:41 am

		Cost Center Description	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	UTILIZATION REVIEW	Subtotal	
			13.00	16.00	17.00	17.01	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	15,879					13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	86,848				16.00
17.00	01700	SOCIAL SERVICE	0	0	0			17.00
17.01	01701	UTILIZATION REVIEW	0	0	0	8,276		17.01
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,488	31,538	0	7,437	257,131	30.00
31.00	03100	INTENSIVE CARE UNIT	1,991	0	0	839	79,432	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	26,884	0	0	212,260	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	49,488	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	3,408	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	81,767	54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	0	0	0	4,133	54.01
54.02	03480	ONCOLOGY	0	0	0	0	137,737	54.02
57.00	05700	CT SCAN	0	0	0	0	32,146	57.00
60.00	06000	LABORATORY	0	0	0	0	75,116	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	20,650	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	39,024	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	718	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	232	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	3,384	69.00
69.01	06901	CARDIAC REHAB	0	0	0	0	65,596	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	2,966	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	28,853	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	125,286	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	146,911	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	146,739	88.02
90.00	09000	CLINIC	0	0	0	0	3,331	90.00
90.01	09001	RHEUMATOLOGY	0	0	0	0	12,674	90.01
91.00	09100	EMERGENCY	7,400	28,426	0	0	184,602	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	15,879	86,848	0	8,276	1,713,584	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	9,875	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	338,266	192.00
192.01	19201	JOHNSON/NICHOLS WIC	0	0	0	0	3,758	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	VACANT SPACE	0	0	0	0	0	194.00
194.01	07951	BOARD OF HEALTH	0	0	0	0	14,347	194.01
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)	15,879	86,848	0	8,276	2,079,830	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1333 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part II Date/Time Prepared: 5/31/2023 8:41 am

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE				17.00
17.01	01701	UTILIZATION REVIEW				17.01
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	257,131		30.00
31.00	03100	INTENSIVE CARE UNIT	0	79,432		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	212,260		50.00
51.00	05100	RECOVERY ROOM	0	49,488		51.00
53.00	05300	ANESTHESIOLOGY	0	3,408		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	81,767		54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	4,133		54.01
54.02	03480	ONCOLOGY	0	137,737		54.02
57.00	05700	CT SCAN	0	32,146		57.00
60.00	06000	LABORATORY	0	75,116		60.00
65.00	06500	RESPIRATORY THERAPY	0	20,650		65.00
66.00	06600	PHYSICAL THERAPY	0	39,024		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	718		67.00
68.00	06800	SPEECH PATHOLOGY	0	232		68.00
69.00	06900	ELECTROCARDIOLOGY	0	3,384		69.00
69.01	06901	CARDIAC REHAB	0	65,596		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,966		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	28,853		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	125,286		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	146,911		88.01
88.02	08802	RURAL HEALTH CLINIC III	0	146,739		88.02
90.00	09000	CLINIC	0	3,331		90.00
90.01	09001	RHEUMATOLOGY	0	12,674		90.01
91.00	09100	EMERGENCY	0	184,602		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0			92.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	1,713,584		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	9,875		190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	338,266		192.00
192.01	19201	JOHNSON/NICHOLS WIC	0	3,758		192.01
193.00	19300	NONPAID WORKERS	0	0		193.00
194.00	07950	VACANT SPACE	0	0		194.00
194.01	07951	BOARD OF HEALTH	0	14,347		194.01
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	2,079,830		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1333 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B-1 | Date/Time Prepared: 5/31/2023 8:41 am

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
			1.00	4.00	5A	5.00	7.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	112,566					1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	153	26,444,670				4.00
5.00	00500	ADMINISTRATIVE & GENERAL	14,628	3,176,916	-7,405,718	42,869,416		5.00
7.00	00700	OPERATION OF PLANT	8,823	356,978	0	1,882,874	88,962	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	676	31,654	0	276,942	676	8.00
9.00	00900	HOUSEKEEPING	282	426,531	0	654,948	282	9.00
10.00	01000	DIETARY	3,389	148,637	0	458,212	3,389	10.00
11.00	01100	CAFETERIA	1,604	347,932	0	867,667	1,604	11.00
13.00	01300	NURSING ADMINISTRATION	665	185,811	0	288,833	665	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,952	290,310	0	603,350	3,952	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
17.01	01701	UTILIZATION REVIEW	333	118,464	0	161,747	333	17.01
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,151	2,307,829	0	1,759,018	6,151	30.00
31.00	03100	INTENSIVE CARE UNIT	2,841	481,123	0	1,038,633	2,841	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,181	718,921	0	1,537,707	8,181	50.00
51.00	05100	RECOVERY ROOM	2,295	113,477	0	213,340	2,295	51.00
53.00	05300	ANESTHESIOLOGY	0	869,541	0	406,208	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,031	1,279,752	0	2,036,383	3,031	54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	140	0	0	198,218	140	54.01
54.02	03480	ONCOLOGY	4,857	396,606	0	5,668,632	4,857	54.02
57.00	05700	CT SCAN	1,320	213,913	0	662,860	1,320	57.00
60.00	06000	LABORATORY	2,510	922,887	0	2,997,868	2,510	60.00
65.00	06500	RESPIRATORY THERAPY	700	506,139	0	721,059	700	65.00
66.00	06600	PHYSICAL THERAPY	1,704	0	0	556,738	1,704	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	113,729	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	36,708	0	68.00
69.00	06900	ELECTROCARDIOLOGY	100	86,056	0	162,846	100	69.00
69.01	06901	CARDIAC REHAB	3,024	267,463	0	398,574	3,024	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	469,781	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	896	351,758	0	1,469,290	896	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	5,436	1,347,481	0	2,041,174	5,436	88.00
88.01	08801	RURAL HEALTH CLINIC II	6,500	1,458,995	0	2,198,067	6,500	88.01
88.02	08802	RURAL HEALTH CLINIC III	6,500	1,421,161	0	2,171,324	6,500	88.02
90.00	09000	CLINIC	162	0	0	2,993	162	90.00
90.01	09001	RHEUMATOLOGY	471	428,783	0	297,303	471	90.01
91.00	09100	EMERGENCY	5,806	3,334,763	0	3,084,733	5,806	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	97,130	21,589,881	-7,405,718	35,437,759	73,526	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	477	0	0	8,813	477	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	14,266	4,588,712	0	6,985,286	14,266	192.00
192.01	19201	JOHNSON/NICHOLS WIC	0	266,077	0	424,754	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	VACANT SPACE	0	0	0	0	0	194.00
194.01	07951	BOARD OF HEALTH	693	0	0	12,804	693	194.01
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)	2,079,830	6,506,171		7,405,718	2,208,142	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	18.476538	0.246030		0.172751	24.821182	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		2,827		270,617	174,943	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.000107		0.006313	1.966491	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1333 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B-1 | Date/Time Prepared: 5/31/2023 8:41 am

		Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (TOTAL PATIENT DAYS)	CAFETERIA (MANHOURS)	NURSING ADMINISTRATION (DIRECT NURSING HOURS)	
			8.00	9.00	10.00	11.00	13.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE	178,564					8.00
9.00	00900	HOUSEKEEPING	1,002	70,004				9.00
10.00	01000	DIETARY	740	3,389	1,548			10.00
11.00	01100	CAFETERIA	0	1,604	0	314,317		11.00
13.00	01300	NURSING ADMINISTRATION	0	665	0	2,821	98,571	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	3,952	0	13,465	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
17.01	01701	UTILIZATION REVIEW	0	333	0	3,145	0	17.01
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	38,845	6,151	1,391	40,277	40,277	30.00
31.00	03100	INTENSIVE CARE UNIT	29,996	2,841	157	12,359	12,359	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	25,348	8,343	0	40,296	0	50.00
51.00	05100	RECOVERY ROOM	2,746	2,295	0	5,249	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	6,125	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	13,358	3,031	0	42,524	0	54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	140	0	0	0	54.01
54.02	03480	ONCOLOGY	5,740	4,857	0	11,584	0	54.02
57.00	05700	CT SCAN	0	1,320	0	6,229	0	57.00
60.00	06000	LABORATORY	0	2,510	0	36,047	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	700	0	13,321	0	65.00
66.00	06600	PHYSICAL THERAPY	4,931	1,704	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	100	0	2,350	0	69.00
69.01	06901	CARDIAC REHAB	0	3,024	0	6,510	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	896	0	8,923	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	3,997	5,436	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	RHEUMATOLOGY	0	471	0	8,602	0	90.01
91.00	09100	EMERGENCY	43,479	5,806	0	45,935	45,935	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	170,182	59,568	1,548	305,762	98,571	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	477	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	8,382	9,266	0	0	0	192.00
192.01	19201	JOHNSON/NICHOLS WIC	0	0	0	8,555	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	VACANT SPACE	0	0	0	0	0	194.00
194.01	07951	BOARD OF HEALTH	0	693	0	0	0	194.01
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)	341,563	777,008	660,519	1,075,174	372,266	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	1.912832	11.099480	426.691860	3.420668	3.776628	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	15,570	10,033	72,741	38,535	15,879	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.087196	0.143320	46.990310	0.122599	0.161092	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1333 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B-1 | Date/Time Prepared: 5/31/2023 8:41 am

		Cost Center Description	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (PATIENT DAYS)	UTILIZATION REVIEW (TOTAL PATIENT DAYS)		
			16.00	17.00	17.01		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	84,146				16.00
17.00	01700	SOCIAL SERVICE	0	0			17.00
17.01	01701	UTILIZATION REVIEW	0	0	1,548		17.01
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	30,556	0	1,391		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	157		31.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	26,048	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0	0		51.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	0	0		54.01
54.02	03480	ONCOLOGY	0	0	0		54.02
57.00	05700	CT SCAN	0	0	0		57.00
60.00	06000	LABORATORY	0	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
69.01	06901	CARDIAC REHAB	0	0	0		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0		88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0		88.02
90.00	09000	CLINIC	0	0	0		90.00
90.01	09001	RHEUMATOLOGY	0	0	0		90.01
91.00	09100	EMERGENCY	27,542	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
		SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	84,146	0	1,548		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0		190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0		192.00
192.01	19201	JOHNSON/NICHOLS WIC	0	0	0		192.01
193.00	19300	NONPAID WORKERS	0	0	0		193.00
194.00	07950	VACANT SPACE	0	0	0		194.00
194.01	07951	BOARD OF HEALTH	0	0	0		194.01
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)	895,596	0	212,408		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	10.643358	0.000000	137.214470		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	86,848	0	8,276		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1.032111	0.000000	5.346253		205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)					206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)					207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1333 | Period: From 01/01/2022 To 12/31/2022 | Worksheet C Part I Date/Time Prepared: 5/31/2023 8:41 am

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	3,757,639		3,757,639	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	1,554,971		1,554,971	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,562,575		2,562,575	0	0	50.00
51.00	05100	RECOVERY ROOM	355,841		355,841	0	0	51.00
53.00	05300	ANESTHESIOLOGY	497,333		497,333	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,668,058		2,668,058	0	0	54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	237,489		237,489	0	0	54.01
54.02	03480	ONCOLOGY	6,872,965		6,872,965	0	0	54.02
57.00	05700	CT SCAN	846,092		846,092	0	0	57.00
60.00	06000	LABORATORY	3,729,219		3,729,219	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	916,335	0	916,335	0	0	65.00
66.00	06600	PHYSICAL THERAPY	723,556	0	723,556	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	133,376	0	133,376	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	43,049	0	43,049	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	202,609		202,609	0	0	69.00
69.01	06901	CARDIAC REHAB	598,321		598,321	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0		0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	550,936		550,936	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,785,819		1,785,819	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,596,700		2,596,700	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	2,739,123		2,739,123	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	2,707,760		2,707,760	0	0	88.02
90.00	09000	CLINIC	7,531		7,531	0	0	90.00
90.01	09001	RHEUMATOLOGY	395,006		395,006	0	0	90.01
91.00	09100	EMERGENCY	4,533,094		4,533,094	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,196,842		1,196,842		0	92.00
200.00		Subtotal (see instructions)	42,212,239	0	42,212,239	0	0	200.00
201.00		Less Observation Beds	1,196,842		1,196,842		0	201.00
202.00		Total (see instructions)	41,015,397	0	41,015,397	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1333 | Period: From 01/01/2022 To 12/31/2022 | Worksheet C Part I Date/Time Prepared: 5/31/2023 8:41 am

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,611,202		2,611,202			30.00
31.00	03100	INTENSIVE CARE UNIT	627,573		627,573			31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	316,968	3,855,321	4,172,289	0.614189	0.000000	50.00
51.00	05100	RECOVERY ROOM	51,364	509,599	560,963	0.634340	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	19,593	445,322	464,915	1.069729	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	730,225	8,361,198	9,091,423	0.293470	0.000000	54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	20,712	1,334,092	1,354,804	0.175294	0.000000	54.01
54.02	03480	ONCOLOGY	8,216	10,948,545	10,956,761	0.627281	0.000000	54.02
57.00	05700	CT SCAN	501,571	13,875,294	14,376,865	0.058851	0.000000	57.00
60.00	06000	LABORATORY	1,452,578	15,478,212	16,930,790	0.220263	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	1,191,475	838,181	2,029,656	0.451473	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	370,746	2,246,545	2,617,291	0.276452	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	171,208	382,408	553,616	0.240918	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	26,789	139,905	166,694	0.258252	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	25,546	813,640	839,186	0.241435	0.000000	69.00
69.01	06901	CARDIAC REHAB	0	1,071,179	1,071,179	0.558563	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0.000000	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	208,354	331,597	539,951	1.020344	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,019,698	2,145,612	3,165,310	0.564185	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	2,231,878	2,231,878			88.00
88.01	08801	RURAL HEALTH CLINIC II	0	2,406,213	2,406,213			88.01
88.02	08802	RURAL HEALTH CLINIC III	0	2,138,876	2,138,876			88.02
90.00	09000	CLINIC	0	6,517	6,517	1.155593	0.000000	90.00
90.01	09001	RHEUMATOLOGY	0	319,969	319,969	1.234513	0.000000	90.01
91.00	09100	EMERGENCY	274,805	19,748,806	20,023,611	0.226387	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	62,010	1,407,239	1,469,249	0.814594	0.000000	92.00
200.00		Subtotal (see instructions)	9,690,633	91,036,148	100,726,781			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	9,690,633	91,036,148	100,726,781			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1333 | Period: From 01/01/2022 To 12/31/2022 | Worksheet C Part I Date/Time Prepared: 5/31/2023 8:41 am

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	NUCLEAR MEDICINE-DIAGNOSTIC	0.000000		54.01
54.02	03480	ONCOLOGY	0.000000		54.02
57.00	05700	CT SCAN	0.000000		57.00
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
69.01	06901	CARDIAC REHAB	0.000000		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC			88.00
88.01	08801	RURAL HEALTH CLINIC II			88.01
88.02	08802	RURAL HEALTH CLINIC III			88.02
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	RHEUMATOLOGY	0.000000		90.01
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
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: 15-1333 | Period: From 01/01/2022 To 12/31/2022 | Worksheet C Part I Date/Time Prepared: 5/31/2023 8:41 am

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,757,639		3,757,639	0	3,757,639	30.00
31.00	03100	INTENSIVE CARE UNIT	1,554,971		1,554,971	0	1,554,971	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,562,575		2,562,575	0	2,562,575	50.00
51.00	05100	RECOVERY ROOM	355,841		355,841	0	355,841	51.00
53.00	05300	ANESTHESIOLOGY	497,333		497,333	0	497,333	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,668,058		2,668,058	0	2,668,058	54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	237,489		237,489	0	237,489	54.01
54.02	03480	ONCOLOGY	6,872,965		6,872,965	0	6,872,965	54.02
57.00	05700	CT SCAN	846,092		846,092	0	846,092	57.00
60.00	06000	LABORATORY	3,729,219		3,729,219	0	3,729,219	60.00
65.00	06500	RESPIRATORY THERAPY	916,335	0	916,335	0	916,335	65.00
66.00	06600	PHYSICAL THERAPY	723,556	0	723,556	0	723,556	66.00
67.00	06700	OCCUPATIONAL THERAPY	133,376	0	133,376	0	133,376	67.00
68.00	06800	SPEECH PATHOLOGY	43,049	0	43,049	0	43,049	68.00
69.00	06900	ELECTROCARDIOLOGY	202,609		202,609	0	202,609	69.00
69.01	06901	CARDIAC REHAB	598,321		598,321	0	598,321	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0		0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	550,936		550,936	0	550,936	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,785,819		1,785,819	0	1,785,819	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,596,700		2,596,700	0	2,596,700	88.00
88.01	08801	RURAL HEALTH CLINIC II	2,739,123		2,739,123	0	2,739,123	88.01
88.02	08802	RURAL HEALTH CLINIC III	2,707,760		2,707,760	0	2,707,760	88.02
90.00	09000	CLINIC	7,531		7,531	0	7,531	90.00
90.01	09001	RHEUMATOLOGY	395,006		395,006	0	395,006	90.01
91.00	09100	EMERGENCY	4,533,094		4,533,094	0	4,533,094	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,196,842		1,196,842		1,196,842	92.00
200.00		Subtotal (see instructions)	42,212,239	0	42,212,239	0	42,212,239	200.00
201.00		Less Observation Beds	1,196,842		1,196,842		1,196,842	201.00
202.00		Total (see instructions)	41,015,397	0	41,015,397	0	41,015,397	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1333 | Period: From 01/01/2022 To 12/31/2022 | Worksheet C Part I Date/Time Prepared: 5/31/2023 8:41 am

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,611,202		2,611,202			30.00
31.00	03100	INTENSIVE CARE UNIT	627,573		627,573			31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	316,968	3,855,321	4,172,289	0.614189	0.000000	50.00
51.00	05100	RECOVERY ROOM	51,364	509,599	560,963	0.634340	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	19,593	445,322	464,915	1.069729	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	730,225	8,361,198	9,091,423	0.293470	0.000000	54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	20,712	1,334,092	1,354,804	0.175294	0.000000	54.01
54.02	03480	ONCOLOGY	8,216	10,948,545	10,956,761	0.627281	0.000000	54.02
57.00	05700	CT SCAN	501,571	13,875,294	14,376,865	0.058851	0.000000	57.00
60.00	06000	LABORATORY	1,452,578	15,478,212	16,930,790	0.220263	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	1,191,475	838,181	2,029,656	0.451473	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	370,746	2,246,545	2,617,291	0.276452	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	171,208	382,408	553,616	0.240918	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	26,789	139,905	166,694	0.258252	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	25,546	813,640	839,186	0.241435	0.000000	69.00
69.01	06901	CARDIAC REHAB	0	1,071,179	1,071,179	0.558563	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0.000000	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	208,354	331,597	539,951	1.020344	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,019,698	2,145,612	3,165,310	0.564185	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	2,231,878	2,231,878	1.163460	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	2,406,213	2,406,213	1.138354	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	2,138,876	2,138,876	1.265973	0.000000	88.02
90.00	09000	CLINIC	0	6,517	6,517	1.155593	0.000000	90.00
90.01	09001	RHEUMATOLOGY	0	319,969	319,969	1.234513	0.000000	90.01
91.00	09100	EMERGENCY	274,805	19,748,806	20,023,611	0.226387	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	62,010	1,407,239	1,469,249	0.814594	0.000000	92.00
200.00		Subtotal (see instructions)	9,690,633	91,036,148	100,726,781			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	9,690,633	91,036,148	100,726,781			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1333 | Period: From 01/01/2022 To 12/31/2022 | Worksheet C Part I Date/Time Prepared: 5/31/2023 8:41 am

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
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	NUCLEAR MEDICINE-DIAGNOSTIC	0.000000		54.01
54.02	03480	ONCOLOGY	0.000000		54.02
57.00	05700	CT SCAN	0.000000		57.00
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
69.01	06901	CARDIAC REHAB	0.000000		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000		88.02
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	RHEUMATOLOGY	0.000000		90.01
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
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: 15-1333 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part II Date/Time Prepared: 5/31/2023 8:41 am

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	212,260	4,172,289	0.050874	167,077	8,500	50.00
51.00	05100	RECOVERY ROOM	49,488	560,963	0.088220	25,188	2,222	51.00
53.00	05300	ANESTHESIOLOGY	3,408	464,915	0.007330	11,150	82	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	81,767	9,091,423	0.008994	373,749	3,361	54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	4,133	1,354,804	0.003051	18,106	55	54.01
54.02	03480	ONCOLOGY	137,737	10,956,761	0.012571	968	12	54.02
57.00	05700	CT SCAN	32,146	14,376,865	0.002236	192,606	431	57.00
60.00	06000	LABORATORY	75,116	16,930,790	0.004437	725,150	3,217	60.00
65.00	06500	RESPIRATORY THERAPY	20,650	2,029,656	0.010174	563,448	5,733	65.00
66.00	06600	PHYSICAL THERAPY	39,024	2,617,291	0.014910	168,029	2,505	66.00
67.00	06700	OCCUPATIONAL THERAPY	718	553,616	0.001297	77,700	101	67.00
68.00	06800	SPEECH PATHOLOGY	232	166,694	0.001392	14,655	20	68.00
69.00	06900	ELECTROCARDIOLOGY	3,384	839,186	0.004032	13,345	54	69.00
69.01	06901	CARDIAC REHAB	65,596	1,071,179	0.061237	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,966	539,951	0.005493	78,366	430	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	28,853	3,165,310	0.009115	516,088	4,704	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	125,286	2,231,878	0.056135	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	146,911	2,406,213	0.061055	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	146,739	2,138,876	0.068606	0	0	88.02
90.00	09000	CLINIC	3,331	6,517	0.511125	0	0	90.00
90.01	09001	RHEUMATOLOGY	12,674	319,969	0.039610	0	0	90.01
91.00	09100	EMERGENCY	184,602	20,023,611	0.009219	17,096	158	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	81,899	1,469,249	0.055742	2,220	124	92.00
200.00		Total (lines 50 through 199)	1,458,920	97,488,006		2,964,941	31,709	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1333 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part IV Date/Time Prepared: 5/31/2023 8:41 am

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	NUCLEAR MEDICINE-DIAGNOSTIC	0	0	0	0	0	54.01
54.02	03480	ONCOLOGY	0	0	0	0	0	54.02
57.00	05700	CT SCAN	0	0	0	0	0	57.00
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
69.01	06901	CARDIAC REHAB	0	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	RHEUMATOLOGY	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1333 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part IV Date/Time Prepared: 5/31/2023 8:41 am

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	4,172,289	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	560,963	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	464,915	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	9,091,423	0.000000	54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	0	0	1,354,804	0.000000	54.01
54.02	03480	ONCOLOGY	0	0	0	10,956,761	0.000000	54.02
57.00	05700	CT SCAN	0	0	0	14,376,865	0.000000	57.00
60.00	06000	LABORATORY	0	0	0	16,930,790	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	2,029,656	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,617,291	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	553,616	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	166,694	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	839,186	0.000000	69.00
69.01	06901	CARDIAC REHAB	0	0	0	1,071,179	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	539,951	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	3,165,310	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	2,231,878	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	2,406,213	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	2,138,876	0.000000	88.02
90.00	09000	CLINIC	0	0	0	6,517	0.000000	90.00
90.01	09001	RHEUMATOLOGY	0	0	0	319,969	0.000000	90.01
91.00	09100	EMERGENCY	0	0	0	20,023,611	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	1,469,249	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	97,488,006		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1333 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part IV Date/Time Prepared: 5/31/2023 8:41 am

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	167,077	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	25,188	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	11,150	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	373,749	0	0	0	54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0.000000	18,106	0	0	0	54.01
54.02	03480	ONCOLOGY	0.000000	968	0	0	0	54.02
57.00	05700	CT SCAN	0.000000	192,606	0	0	0	57.00
60.00	06000	LABORATORY	0.000000	725,150	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	563,448	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	168,029	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	77,700	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	14,655	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	13,345	0	0	0	69.00
69.01	06901	CARDIAC REHAB	0.000000	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	78,366	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	516,088	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000	0	0	0	0	88.02
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	RHEUMATOLOGY	0.000000	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.000000	17,096	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	2,220	0	0	0	92.00
200.00		Total (lines 50 through 199)		2,964,941	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1333 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part V Date/Time Prepared: 5/31/2023 8:41 am

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	0.614189	0	904,981	0	0	50.00
51.00	05100	RECOVERY ROOM	0.634340	0	83,018	0	0	51.00
53.00	05300	ANESTHESIOLOGY	1.069729	0	69,639	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.293470	0	1,689,190	0	0	54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0.175294	0	457,325	0	0	54.01
54.02	03480	ONCOLOGY	0.627281	0	5,236,417	174	0	54.02
57.00	05700	CT SCAN	0.058851	0	3,359,898	4	0	57.00
60.00	06000	LABORATORY	0.220263	0	4,330,300	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.451473	0	163,621	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.276452	0	603,281	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.240918	0	88,421	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.258252	0	20,992	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.241435	0	207,421	0	0	69.00
69.01	06901	CARDIAC REHAB	0.558563	0	302,853	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1.020344	0	114,223	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.564185	0	498,735	10	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC						88.00
88.01	08801	RURAL HEALTH CLINIC II						88.01
88.02	08802	RURAL HEALTH CLINIC III						88.02
90.00	09000	CLINIC	1.155593	0	1,017	0	0	90.00
90.01	09001	RHEUMATOLOGY	1.234513	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.226387	0	3,518,656	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.814594	0	385,451	0	0	92.00
200.00		Subtotal (see instructions)		0	22,035,439	188	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	22,035,439	188	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1333 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part V Date/Time Prepared: 5/31/2023 8:41 am

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	555,829	0		50.00
51.00	05100	RECOVERY ROOM	52,662	0		51.00
53.00	05300	ANESTHESIOLOGY	74,495	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	495,727	0		54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	80,166	0		54.01
54.02	03480	ONCOLOGY	3,284,705	109		54.02
57.00	05700	CT SCAN	197,733	0		57.00
60.00	06000	LABORATORY	953,805	0		60.00
65.00	06500	RESPIRATORY THERAPY	73,870	0		65.00
66.00	06600	PHYSICAL THERAPY	166,778	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	21,302	0		67.00
68.00	06800	SPEECH PATHOLOGY	5,421	0		68.00
69.00	06900	ELECTROCARDIOLOGY	50,079	0		69.00
69.01	06901	CARDIAC REHAB	169,162	0		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	116,547	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	281,379	6		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC				88.00
88.01	08801	RURAL HEALTH CLINIC II				88.01
88.02	08802	RURAL HEALTH CLINIC III				88.02
90.00	09000	CLINIC	1,175	0		90.00
90.01	09001	RHEUMATOLOGY	0	0		90.01
91.00	09100	EMERGENCY	796,578	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	313,986	0		92.00
200.00		Subtotal (see instructions)	7,691,399	115		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	7,691,399	115		202.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-1333	Period: From 01/01/2022 To 12/31/2022	Worksheet D-1 Date/Time Prepared: 5/31/2023 8:41 am
	Title XVIII	Hospital	Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,226	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,100	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)	1,391	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	126	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	732	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)	108	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	250.44	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)	3,757,639	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)	212,697	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,544,942	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)	3,544,942	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)	1,688.07	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,235,667	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)	1,235,667	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1333 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-1 | Date/Time Prepared: 5/31/2023 8:41 am

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	1,554,971	157	9,904.27	68	673,490	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	1,118,413	48.00
48.01	Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)	0	48.01
49.00	Total Program inpatient costs (sum of lines 41 through 48.01)(see instructions)	3,027,570	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)	182,312	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	182,312	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)	709	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,688.07	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,196,842	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1333 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-1 | Date/Time Prepared: 5/31/2023 8:41 am

Title XVIII | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	257,131	3,757,639	0.068429	1,196,842	81,899	90.00
91.00	Nursing Program cost	0	3,757,639	0.000000	1,196,842	0	91.00
92.00	Allied health cost	0	3,757,639	0.000000	1,196,842	0	92.00
93.00	All other Medical Education	0	3,757,639	0.000000	1,196,842	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-1333	Period: From 01/01/2022 To 12/31/2022	Worksheet D-1 Date/Time Prepared: 5/31/2023 8:41 am
	Title XIX	Hospital	Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,226	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,100	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)	1,391	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	126	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	52	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	250.44	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)	3,757,639	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)	212,697	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,544,942	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)	3,544,942	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)	1,688.07	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	87,780	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)	87,780	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1333 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-1 | Date/Time Prepared: 5/31/2023 8:41 am

Title XIX | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	1,554,971	157	9,904.27	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)	81,754	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)	169,534	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)	709	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,688.07	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,196,842	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1333 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-1 | Date/Time Prepared: 5/31/2023 8:41 am

Title XIX | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	257,131	3,757,639	0.068429	1,196,842	81,899	90.00
91.00	Nursing Program cost	0	3,757,639	0.000000	1,196,842	0	91.00
92.00	Allied health cost	0	3,757,639	0.000000	1,196,842	0	92.00
93.00	All other Medical Education	0	3,757,639	0.000000	1,196,842	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1333 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-3 | Date/Time Prepared: 5/31/2023 8:41 am

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		1,302,460		30.00
31.00	03100	INTENSIVE CARE UNIT		287,185		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.614189	167,077	102,617	50.00
51.00	05100	RECOVERY ROOM	0.634340	25,188	15,978	51.00
53.00	05300	ANESTHESIOLOGY	1.069729	11,150	11,927	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.293470	373,749	109,684	54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0.175294	18,106	3,174	54.01
54.02	03480	ONCOLOGY	0.627281	968	607	54.02
57.00	05700	CT SCAN	0.058851	192,606	11,335	57.00
60.00	06000	LABORATORY	0.220263	725,150	159,724	60.00
65.00	06500	RESPIRATORY THERAPY	0.451473	563,448	254,382	65.00
66.00	06600	PHYSICAL THERAPY	0.276452	168,029	46,452	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.240918	77,700	18,719	67.00
68.00	06800	SPEECH PATHOLOGY	0.258252	14,655	3,785	68.00
69.00	06900	ELECTROCARDIOLOGY	0.241435	13,345	3,222	69.00
69.01	06901	CARDIAC REHAB	0.558563	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1.020344	78,366	79,960	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.564185	516,088	291,169	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000		0	88.02
90.00	09000	CLINIC	1.155593	0	0	90.00
90.01	09001	RHEUMATOLOGY	1.234513	0	0	90.01
91.00	09100	EMERGENCY	0.226387	17,096	3,870	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.814594	2,220	1,808	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		2,964,941	1,118,413	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		2,964,941		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-1333 | Component CCN: 15-Z333 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-3 | Date/Time Prepared: 5/31/2023 8:41 am

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	0.614189	916	563	50.00
51.00	05100	RECOVERY ROOM	0.634340	0	0	51.00
53.00	05300	ANESTHESIOLOGY	1.069729	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.293470	4,055	1,190	54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0.175294	2,087	366	54.01
54.02	03480	ONCOLOGY	0.627281	0	0	54.02
57.00	05700	CT SCAN	0.058851	1,888	111	57.00
60.00	06000	LABORATORY	0.220263	21,181	4,665	60.00
65.00	06500	RESPIRATORY THERAPY	0.451473	55,439	25,029	65.00
66.00	06600	PHYSICAL THERAPY	0.276452	52,919	14,630	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.240918	27,986	6,742	67.00
68.00	06800	SPEECH PATHOLOGY	0.258252	401	104	68.00
69.00	06900	ELECTROCARDIOLOGY	0.241435	0	0	69.00
69.01	06901	CARDIAC REHAB	0.558563	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1.020344	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.564185	23,475	13,244	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000		0	88.02
90.00	09000	CLINIC	1.155593	0	0	90.00
90.01	09001	RHEUMATOLOGY	1.234513	0	0	90.01
91.00	09100	EMERGENCY	0.226387	71	16	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.814594	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		190,418	66,660	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)		190,418		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1333 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-3 | Date/Time Prepared: 5/31/2023 8:41 am

Title XIX | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		89,775		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.614189	8,523	5,235	50.00
51.00	05100	RECOVERY ROOM	0.634340	1,184	751	51.00
53.00	05300	ANESTHESIOLOGY	1.069729	714	764	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.293470	22,738	6,673	54.00
54.01	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0.175294	0	0	54.01
54.02	03480	ONCOLOGY	0.627281	0	0	54.02
57.00	05700	CT SCAN	0.058851	26,397	1,553	57.00
60.00	06000	LABORATORY	0.220263	43,735	9,633	60.00
65.00	06500	RESPIRATORY THERAPY	0.451473	32,723	14,774	65.00
66.00	06600	PHYSICAL THERAPY	0.276452	3,442	952	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.240918	1,359	327	67.00
68.00	06800	SPEECH PATHOLOGY	0.258252	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.241435	1,909	461	69.00
69.01	06901	CARDIAC REHAB	0.558563	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1.020344	4,327	4,415	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.564185	29,355	16,562	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	1.163460	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	1.138354	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	1.265973	0	0	88.02
90.00	09000	CLINIC	1.155593	0	0	90.00
90.01	09001	RHEUMATOLOGY	1.234513	0	0	90.01
91.00	09100	EMERGENCY	0.226387	31,547	7,142	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.814594	15,360	12,512	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		223,313	81,754	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)		223,313		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1333	Period: From 01/01/2022 To 12/31/2022	Worksheet E Part B Date/Time Prepared: 5/31/2023 8:41 am
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	7,691,514	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	OPPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	7,691,514	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	7,768,429	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)	73,760	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	3,424,782	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)	4,269,887	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)	4,269,887	30.00
31.00	Primary payer payments	6,730	31.00
32.00	Subtotal (line 30 minus line 31)	4,263,157	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)	829,153	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	538,949	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	356,904	36.00
37.00	Subtotal (see instructions)	4,802,106	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)	4,802,106	40.00
40.01	Sequestration adjustment (see instructions)	60,506	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	3,797,648	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)	943,952	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: 15-1333	Period: From 01/01/2022 To 12/31/2022	Worksheet E Part B Date/Time Prepared: 5/31/2023 8:41 am
	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: 15-1333 | Period: From 01/01/2022 To 12/31/2022 | Worksheet E-1 Part I Date/Time Prepared: 5/31/2023 8:41 am

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		2,162,642		3,797,648	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2,162,642		3,797,648	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		631,425		943,952	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		2,794,067		4,741,600	7.00

			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor	WISCONSIN PHYSICIAN SERVICES	08001		8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-1333 | Component CCN: 15-Z333 | Period: From 01/01/2022 To 12/31/2022 | Worksheet E-1 Part I | Date/Time Prepared: 5/31/2023 8:41 am

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		196,652		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)		196,652		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		51,117		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		247,769		0	7.00

			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor	WISCONSIN PHYSICIAN SERVICES	08001		8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-1333	Period: From 01/01/2022 To 12/31/2022	Worksheet E-1 Part II Date/Time Prepared: 5/31/2023 8:41 am
	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: 15-1333 | Component CCN: 15-Z333 | Period: From 01/01/2022 To 12/31/2022 | Worksheet E-2 | Date/Time Prepared: 5/31/2023 8:41 am

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)	184,135	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)	67,327	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	108	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)	251,462	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	251,462	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)	251,462	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	1,556	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (see instructions)	249,906	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)	1,575	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	1,024	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	250,930	0	19.00
19.01	Sequestration adjustment (see instructions)	3,161	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	196,652	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)	51,117	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: 15-1333	Period: From 01/01/2022 To 12/31/2022	Worksheet E-3 Part V Date/Time Prepared: 5/31/2023 8:41 am
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	3,027,570	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)	3,027,570	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	3,057,846	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)	3,057,846	19.00
20.00	Deductibles (exclude professional component)	275,340	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	2,782,506	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	2,782,506	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	72,639	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	47,215	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	14,374	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	2,829,721	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)	2,829,721	30.00
30.01	Sequestration adjustment (see instructions)	35,654	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	2,162,642	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)	631,425	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: 15-1333	Period: From 01/01/2022 To 12/31/2022	Worksheet E-3 Part VII Date/Time Prepared: 5/31/2023 8:41 am
	Title XIX	Hospital	Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	169,534		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)	169,534	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)	169,534	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	89,775		8.00
9.00	Ancillary service charges	223,313	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)	313,088	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)	313,088	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	143,554	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)	169,534	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)	169,534	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)	169,534	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)	169,534	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	169,534	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)	169,534	0	40.00
41.00	Interim payments	169,534	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 15-1333 | Period: From 01/01/2022 To 12/31/2022 | Worksheet G | Date/Time Prepared: 5/31/2023 8:41 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	21,483,727	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	10,354,011	0	0	0	4.00
5.00	Other receivable	1,935,009	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-6,963,914	0	0	0	6.00
7.00	Inventory	606,464	0	0	0	7.00
8.00	Prepaid expenses	439,794	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)	27,855,091	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	260,501	0	0	0	12.00
13.00	Land improvements	391,896	0	0	0	13.00
14.00	Accumulated depreciation	-336,445	0	0	0	14.00
15.00	Buildings	35,762,484	0	0	0	15.00
16.00	Accumulated depreciation	-26,010,825	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	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	26,863,244	0	0	0	23.00
24.00	Accumulated depreciation	-23,203,676	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)	13,727,179	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	8,246,133	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	244,895	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	8,491,028	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	50,073,298	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	4,821,479	0	0	0	37.00
38.00	Salaries, wages, and fees payable	2,520,335	0	0	0	38.00
39.00	Payroll taxes payable	267,344	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	2,082,714	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	9,691,872	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	4,018,963	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)	4,018,963	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	13,710,835	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	36,362,463				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)	36,362,463	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	50,073,298	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-1333 | Period: From 01/01/2022 To 12/31/2022 | Worksheet G-1 | Date/Time Prepared: 5/31/2023 8:41 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		40,782,567		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-5,081,875				2.00
3.00	Total (sum of line 1 and line 2)		35,700,692		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	Rounding	661,771		0		0	9.00
10.00	Total additions (sum of line 4-9)		661,771		0		10.00
11.00	Subtotal (line 3 plus line 10)		36,362,463		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		36,362,463		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	Rounding		0		9.00
10.00	Total additions (sum of line 4-9)	0		0	10.00
11.00	Subtotal (line 3 plus line 10)	0		0	11.00
12.00	Deductions (debit adjustments) (specify)		0		12.00
13.00			0		13.00
14.00			0		14.00
15.00			0		15.00
16.00			0		16.00
17.00			0		17.00
18.00	Total deductions (sum of lines 12-17)	0		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0	19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 15-1333 | Period: From 01/01/2022 To 12/31/2022 | Worksheet G-2 Parts I & II Date/Time Prepared: 5/31/2023 8:41 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	3,757,381		3,757,381	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)	3,757,381		3,757,381	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	1,849,900		1,849,900	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)	1,849,900		1,849,900	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	5,607,281		5,607,281	17.00
18.00	Ancillary services	6,185,463	63,633,233	69,818,696	18.00
19.00	Outpatient services	348,852	26,321,723	26,670,575	19.00
20.00	RURAL HEALTH CLINIC	0	2,231,878	2,231,878	20.00
20.01	RURAL HEALTH CLINIC II	0	2,406,213	2,406,213	20.01
20.02	RURAL HEALTH CLINIC III	0	2,138,876	2,138,876	20.02
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
27.01	Other Patient Service Revenue - NRCCs	0	6,194,098	6,194,098	27.01
27.02	CENTURY VILLA NET REVENUE	8,574,966	0	8,574,966	27.02
27.03	OTHER (SPECIFY)	0	0	0	27.03
27.04	OTHER (SPECIFY)	0	0	0	27.04
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	20,716,562	102,926,021	123,642,583	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		59,036,893		29.00
30.00	Century Villa Operating Expenses	8,180,865			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)		8,180,865		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)		67,217,758		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 15-1333	Period: From 01/01/2022 To 12/31/2022	Worksheet G-3 Date/Time Prepared: 5/31/2023 8:41 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	123,642,583	1.00
2.00	Less contractual allowances and discounts on patients' accounts	73,423,224	2.00
3.00	Net patient revenues (line 1 minus line 2)	50,219,359	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	67,217,758	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-16,998,399	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	64,780	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	4	10.00
11.00	Rebates and refunds of expenses	12,154	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	56,351	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	131	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	754,750	23.00
24.00	Misc Revenue	1,763,847	24.00
24.01	340B Program Revenue	811,045	24.01
24.02	IGT Revenue	7,412,826	24.02
24.50	COVID-19 PHE Funding	1,040,636	24.50
25.00	Total other income (sum of lines 6-24)	11,916,524	25.00
26.00	Total (line 5 plus line 25)	-5,081,875	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)	-5,081,875	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS | Provider CCN: 15-1333 | Component CCN: 15-8515 | Period: From 01/01/2022 To 12/31/2022 | Worksheet M-1 | Date/Time Prepared: 5/31/2023 8:41 am

RHC I | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	307,601	19,582	327,183	0	327,183	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	432,951	42,350	475,301	-46,052	429,249	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	172,246	21,862	194,108	0	194,108	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	912,798	83,794	996,592	-46,052	950,540	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	144,143	144,143	0	144,143	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	64	64	-25	39	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	144,207	144,207	-25	144,182	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	912,798	228,001	1,140,799	-46,077	1,094,722	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	3,993	0	3,993	0	3,993	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)	3,993	0	3,993	0	3,993	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	6,828	6,828	-709	6,119	29.00
30.00	Administrative Costs	514,962	33,994	548,956	-44,444	504,512	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	514,962	40,822	555,784	-45,153	510,631	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,431,753	268,823	1,700,576	-91,230	1,609,346	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1333 | Component CCN: 15-8515 | Period: From 01/01/2022 To 12/31/2022 | Worksheet M-1 | Date/Time Prepared: 5/31/2023 8:41 am

RHC I | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	327,183		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	429,249		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	0		5.00
6.00	Clinical Psychologist	0	194,108		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	950,540		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	144,143		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	39		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	144,182		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	1,094,722		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	3,993		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	3,993		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	6,119		29.00
30.00	Administrative Costs	-131	504,381		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-131	510,500		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-131	1,609,215		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1333 | Component CCN: 15-8513 | Period: From 01/01/2022 To 12/31/2022 | Worksheet M-1 | Date/Time Prepared: 5/31/2023 8:41 am

RHC II | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	321,917	25,562	347,479	0	347,479	1.00
2.00	Physician Assistant	536,120	59,061	595,181	0	595,181	2.00
3.00	Nurse Practitioner	0	0	0	21,154	21,154	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	21,554	4,087	25,641	0	25,641	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	879,591	88,710	968,301	21,154	989,455	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	102,618	102,618	0	102,618	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	341	341	6	347	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	102,959	102,959	6	102,965	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	879,591	191,669	1,071,260	21,160	1,092,420	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	1,478	0	1,478	41	1,519	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)	1,478	0	1,478	41	1,519	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	6,002	6,002	162	6,164	29.00
30.00	Administrative Costs	548,835	59,933	608,768	10,142	618,910	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	548,835	65,935	614,770	10,304	625,074	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,429,904	257,604	1,687,508	31,505	1,719,013	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1333 | Component CCN: 15-8513 | Period: From 01/01/2022 To 12/31/2022 | Worksheet M-1 | Date/Time Prepared: 5/31/2023 8:41 am

RHC II | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	347,479		1.00
2.00	Physician Assistant	0	595,181		2.00
3.00	Nurse Practitioner	0	21,154		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	25,641		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	989,455		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	102,618		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	347		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	102,965		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	1,092,420		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	1,519		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	1,519		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	6,164		29.00
30.00	Administrative Costs	0	618,910		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	625,074		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	1,719,013		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS | Provider CCN: 15-1333 | Component CCN: 15-8514 | Period: From 01/01/2022 To 12/31/2022 | Worksheet M-1 | Date/Time Prepared: 5/31/2023 8:41 am

RHC III | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	445,070	53,370	498,440	0	498,440	1.00
2.00	Physician Assistant	117,069	15,935	133,004	0	133,004	2.00
3.00	Nurse Practitioner	241,169	23,246	264,415	24,856	289,271	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	75,766	9,427	85,193	0	85,193	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	879,074	101,978	981,052	24,856	1,005,908	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	96,979	96,979	0	96,979	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	150	150	20	170	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	97,129	97,129	20	97,149	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	879,074	199,107	1,078,181	24,876	1,103,057	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	638	0	638	0	638	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)	638	0	638	0	638	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	4,963	4,963	548	5,511	29.00
30.00	Administrative Costs	486,268	75,003	561,271	34,302	595,573	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	486,268	79,966	566,234	34,850	601,084	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,365,980	279,073	1,645,053	59,726	1,704,779	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1333 | Component CCN: 15-8514 | Period: From 01/01/2022 To 12/31/2022 | Worksheet M-1 | Date/Time Prepared: 5/31/2023 8:41 am

RHC III | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	498,440		1.00
2.00	Physician Assistant	0	133,004		2.00
3.00	Nurse Practitioner	0	289,271		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	85,193		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	1,005,908		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	96,979		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	170		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	97,149		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	1,103,057		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	638		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	638		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	5,511		29.00
30.00	Administrative Costs	-3,200	592,373		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-3,200	597,884		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-3,200	1,701,579		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-1333 | Component CCN: 15-8515 | Period: From 01/01/2022 To 12/31/2022 | Worksheet M-2 | Date/Time Prepared: 5/31/2023 8:41 am

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	RHC I Minimum Visits (col. 1 x col. 3)	Cost Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.92	3,404	1	1		1.00
2.00	Physician Assistant	0.00	0	1	0		2.00
3.00	Nurse Practitioner	2.86	5,542	1	3		3.00
4.00	Subtotal (sum of lines 1 through 3)	3.78	8,946		4	8,946	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	1.04	1,403			1,403	6.00
7.00	Clinical Social Worker	0.00	2			2	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)	4.82	10,351			10,351	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)					1,094,722	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					3,993	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					1,098,715	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.996366	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					510,500	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					987,485	15.00
16.00	Total overhead (sum of lines 14 and 15)					1,497,985	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					1,497,985	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					1,492,541	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					2,587,263	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-1333 | Component CCN: 15-8513 | Period: From 01/01/2022 To 12/31/2022 | Worksheet M-2 | Date/Time Prepared: 5/31/2023 8:41 am

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	RHC II Minimum Visits (col. 1 x col. 3)	Cost Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.86	2,342	1	1		1.00
2.00	Physician Assistant	3.35	10,012	1	3		2.00
3.00	Nurse Practitioner	0.11	110	1	0		3.00
4.00	Subtotal (sum of lines 1 through 3)	4.32	12,464		4	12,464	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	1			1	6.00
7.00	Clinical Social Worker	0.21	161			161	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)	4.53	12,626			12,626	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					1,092,420	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					1,519	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					1,093,939	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.998611	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					625,074	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					1,020,110	15.00
16.00	Total overhead (sum of lines 14 and 15)					1,645,184	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					1,645,184	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					1,642,899	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					2,735,319	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-1333 | Component CCN: 15-8514 | Period: From 01/01/2022 To 12/31/2022 | Worksheet M-2 | Date/Time Prepared: 5/31/2023 8:41 am

RHC III | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	1.75	3,004	1	2		1.00
2.00	Physician Assistant	0.89	1,626	1	1		2.00
3.00	Nurse Practitioner	1.90	3,293	1	2		3.00
4.00	Subtotal (sum of lines 1 through 3)	4.54	7,923		5	7,923	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	7			7	6.00
7.00	Clinical Social Worker	0.89	784			784	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	5.43	8,714			8,714	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)					1,103,057	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					638	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					1,103,695	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.999422	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					597,884	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					1,006,181	15.00
16.00	Total overhead (sum of lines 14 and 15)					1,604,065	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					1,604,065	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					1,603,138	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					2,706,195	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 15-1333 Component CCN: 15-8515	Period: From 01/01/2022 To 12/31/2022	Worksheet M-3 Date/Time Prepared: 5/31/2023 8:41 am
	Title XVIII	RHC I	Cost

				1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			2,587,263	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			143,294	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			2,443,969	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			10,351	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)			10,351	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			236.11	7.00
		Calculation of Limit (1)			
		Rate Period N/A	Rate Period 1 (01/01/2022 through 12/31/2022)		
		1.00	2.00		
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	0.00	265.00		8.00
9.00	Rate for Program covered visits (see instructions)	0.00	236.11		9.00
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	0	609		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	143,791		11.00
12.00	Program covered visits for mental health services (from contractor records)	0	45		12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	10,625		13.00
14.00	Limit adjustment for mental health services (see instructions)	0	10,625		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	154,416		16.00
16.01	Total program charges (see instructions)(from contractor's records)		128,679		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		3,415		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		4,098		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.)		105,924		16.04
16.05	Total program cost (see instructions)	0	110,022		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		17,913		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		21,379		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		110,022		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		4,348		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		114,370		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)		114,370		26.00
26.01	Sequestration adjustment (see instructions)		1,441		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		124,278		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)		-11,349		29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0		30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 15-1333 Component CCN: 15-8513	Period: From 01/01/2022 To 12/31/2022	Worksheet M-3 Date/Time Prepared: 5/31/2023 8:41 am
	Title XVIII	RHC II	Cost

				1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			2,735,319	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			90,870	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			2,644,449	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			12,626	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			0	5.00
6.00	Total adjusted visits (line 4 plus line 5)			12,626	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			209.44	7.00
		Calculation of Limit (1)			
		Rate Period N/A	Rate Period 1 (01/01/2022 through 12/31/2022)		
		1.00	2.00		
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	0.00	219.47		8.00
9.00	Rate for Program covered visits (see instructions)	0.00	209.44		9.00
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	0	1,287		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	269,549		11.00
12.00	Program covered visits for mental health services (from contractor records)	0	8		12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	1,676		13.00
14.00	Limit adjustment for mental health services (see instructions)	0	1,676		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	271,225		16.00
16.01	Total program charges (see instructions)(from contractor's records)		260,775		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		10,635		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		11,061		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.)		170,662		16.04
16.05	Total program cost (see instructions)	0	181,723		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		46,837		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		40,661		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		181,723		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		8,772		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		190,495		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)		190,495		26.00
26.01	Sequestration adjustment (see instructions)		2,400		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		189,236		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)		-1,141		29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0		30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 15-1333 Component CCN: 15-8514	Period: From 01/01/2022 To 12/31/2022	Worksheet M-3 Date/Time Prepared: 5/31/2023 8:41 am
	Title XVIII	RHC III	Cost

				1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			2,706,195	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			66,583	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			2,639,612	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			8,714	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			0	5.00
6.00	Total adjusted visits (line 4 plus line 5)			8,714	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			302.92	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	293.29		8.00
9.00	Rate for Program covered visits (see instructions)	0.00	293.29		9.00
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	0	1,000		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	293,290		11.00
12.00	Program covered visits for mental health services (from contractor records)	0	34		12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	9,972		13.00
14.00	Limit adjustment for mental health services (see instructions)	0	9,972		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	303,262		16.00
16.01	Total program charges (see instructions)(from contractor's records)		209,803		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		13,552		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		19,589		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.)		206,836		16.04
16.05	Total program cost (see instructions)	0	226,425		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		25,128		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		34,211		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		226,425		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		8,333		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		234,758		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)		234,758		26.00
26.01	Sequestration adjustment (see instructions)		2,958		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		223,864		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)		7,936		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: 15-1333 | Component CCN: 15-8515 | Period: From 01/01/2022 To 12/31/2022 | Worksheet M-4 | Date/Time Prepared: 5/31/2023 8:41 am

Title XVIII | RHC I | Cost

		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	950,540	950,540	950,540	950,540	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.004723	0.005329	0.002152	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	4,489	5,065	2,046	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	36,597	12,433	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	41,086	17,498	2,046	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	1,094,722	1,094,722	1,094,722	1,094,722	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	1,492,541	1,492,541	1,492,541	1,492,541	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.037531	0.015984	0.001869	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	56,017	23,857	2,790	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	97,103	41,355	4,836	0	10.00
11.00	Total number of injections/infusions (from your records)	452	510	206	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	214.83	81.09	23.48	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	4	41	7	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)	859	3,325	164	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)		143,294	15.00
16.00	Total Program cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount to Wkst. M-3, line 21)		4,348	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 15-1333 | Component CCN: 15-8513 | Period: From 01/01/2022 To 12/31/2022 | Worksheet M-4 | Date/Time Prepared: 5/31/2023 8:41 am

Title XVIII | RHC II | Cost

		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	989,455	989,455	989,455	989,455	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000871	0.004107	0.000878	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	862	4,064	869	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	11,074	19,423	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	11,936	23,487	869	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	1,092,420	1,092,420	1,092,420	1,092,420	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	1,642,899	1,642,899	1,642,899	1,642,899	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.010926	0.021500	0.000795	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	17,950	35,322	1,306	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	29,886	58,809	2,175	0	10.00
11.00	Total number of injections/infusions (from your records)	123	580	124	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	242.98	101.39	17.54	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	2	80	10	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)	486	8,111	175	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)		90,870	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)		8,772	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 15-1333 | Component CCN: 15-8514 | Period: From 01/01/2022 To 12/31/2022 | Worksheet M-4 | Date/Time Prepared: 5/31/2023 8:41 am

Title XVIII | RHC III | Cost

		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	1,005,908	1,005,908	1,005,908	1,005,908	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000728	0.002843	0.001492	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	732	2,860	1,501	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	9,714	12,332	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	10,446	15,192	1,501	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	1,103,057	1,103,057	1,103,057	1,103,057	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	1,603,138	1,603,138	1,603,138	1,603,138	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.009470	0.013773	0.001361	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	15,182	22,080	2,182	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	25,628	37,272	3,683	0	10.00
11.00	Total number of injections/infusions (from your records)	104	406	213	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	246.42	91.80	17.29	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	0	84	36	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	7,711	622	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)		66,583	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)		8,333	16.00

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

Provider CCN: 15-1333 | Component CCN: 15-8515 | Period: From 01/01/2022 To 12/31/2022 | Worksheet M-5 | Date/Time Prepared: 5/31/2023 8:41 am

RHC I | Cost

		Part B mm/dd/yyyy	Part B Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		124,278	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)		124,278	4.00
	TO BE COMPLETED BY CONTRACTOR			
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
	Program to Provider			
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
	Provider to Program			
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		0	6.01
6.02	SETTLEMENT TO PROGRAM		11,349	6.02
7.00	Total Medicare program liability (see instructions)		112,929	7.00

			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor	WISCONSIN PHYSICIAN SERVICES	08001		8.00

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

Provider CCN: 15-1333 | Component CCN: 15-8513 | Period: From 01/01/2022 To 12/31/2022 | Worksheet M-5 | Date/Time Prepared: 5/31/2023 8:41 am

RHC II | Cost

		Part B mm/dd/yyyy	Part B Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		189,236	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)		189,236	4.00
	TO BE COMPLETED BY CONTRACTOR			
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
	Program to Provider			
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
	Provider to Program			
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		0	6.01
6.02	SETTLEMENT TO PROGRAM		1,141	6.02
7.00	Total Medicare program liability (see instructions)		188,095	7.00

			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor	WISCONSIN PHYSICIAN SERVICES	08001		8.00

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

Provider CCN: 15-1333 | Component CCN: 15-8514 | Period: From 01/01/2022 To 12/31/2022 | Worksheet M-5 | Date/Time Prepared: 5/31/2023 8:41 am

RHC III | Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		223,864	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)		223,864	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		7,936	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		231,800	7.00

			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor	WISCONSIN PHYSICIAN SERVICES	08001		8.00