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 03-31-2022

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 15-1305	Period: From 10/01/2021 To 09/30/2022	Worksheet S Parts I-III Date/Time Prepared: 2/23/2023 4:28 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 2/23/2023 Time: 4:28 pm
2. [ ] Manually prepared cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

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 PULASKI MEMORIAL HOSPITAL (15-1305) for the cost reporting period beginning 10/01/2021 and ending 09/30/2022 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	Gregg Malott		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	Gregg Malott			2
3	Signatory Title	CFO			3
4	Date	(Dated when report is electronica			4

	Cost Center Description	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	-81	69,485	0	16,652	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	22,165	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	RURAL HEALTH CLINIC I	0		37,894		0	10.00
10.01	RURAL HEALTH CLINIC II	0		15,818		0	10.01
10.02	RURAL HEALTH CLINIC III	0		9,353		0	10.02
10.03	RURAL HEALTH CLINIC IV	0		2,464		0	10.03
200.00	Total	0	22,084	135,014	0	16,652	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: 15-1305 | Period: From 10/01/2021 To 09/30/2022 | Worksheet S-2 Part I | Date/Time Prepared: 2/23/2023 4:28 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 616 EAST 13TH	PO Box:			1.00
2.00	City: WINAMAC	State: IN	Zip Code: 46996-	County: PULASKI	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	PULASKI MEMORIAL HOSPITAL	151305	99915	1	10/01/2000	N	O	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	PULASKI MEMORIAL HOSPITAL	15Z305	99915		10/01/2000	N	O	P	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	PULASKI MEMORIAL RHC - WINAMAC	158512	99915		08/21/2014	N	O	N	15.00
15.01	Hospital-Based Health Clinic - RHC II	PULASKI MEMORIAL RHC - NORTH JUDSON	158527	99915		03/14/2018	N	O	N	15.01
15.02	Hospital-Based Health Clinic - RHC III	PULASKI MEMORIAL RHC - FRANCESVILLE	158528	99915		03/15/2018	N	O	N	15.02
15.03	Hospital-Based Health Clinic - RHC IV	PULASKI MEMORIAL RHC - KNOX MEDICAL	158554	99915		07/06/2020	N	O	N	15.03
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	10/01/2021	09/30/2022	20.00
21.00	Type of Control (see instructions)	2		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	N		22.00
22.01	Did this hospital receive interim uncompensated care payments 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 final uncompensated care payments 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.	N	N	N	22.04

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1305 | Period: From 10/01/2021 To 09/30/2022 | Worksheet S-2 Part I | Date/Time Prepared: 2/23/2023 4:28 pm

		1.00	2.00	3.00	
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	2	N		23.00

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

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

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

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

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. 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	If line 56 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.				57.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1305 | Period: From 10/01/2021 To 09/30/2022 | Worksheet S-2 Part I | Date/Time Prepared: 2/23/2023 4:28 pm

		V	XVIII	XIX	
		1.00	2.00	3.00	
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.				58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00

		NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
		1.00	2.00	3.00	
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustement? 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: 15-1305 | Period: From 10/01/2021 To 09/30/2022 | Worksheet S-2 Part I Date/Time Prepared: 2/23/2023 4:28 pm

				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: 15-1305 | Period: From 10/01/2021 To 09/30/2022 | Worksheet S-2 Part I Date/Time Prepared: 2/23/2023 4:28 pm

		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

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.06
	Rural Providers			
105.00	Does this hospital qualify as a CAH?	Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N		107.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1305 | Period: From 10/01/2021 To 09/30/2022 | Worksheet S-2 Part I Date/Time Prepared: 2/23/2023 4:28 pm

				V	XIX	
				1.00	2.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.			N		108.00
		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N	109.00
					1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration)for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.				N	110.00
				1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.			N		111.00
		1.00	2.00	3.00		
112.00	Did this hospital participate in the Pennsylvania Rural Health Model 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
	Miscellaneous Cost Reporting Information					
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N			0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N				116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y				117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1				118.00
		Premiums	Losses	Insurance		
		1.00	2.00	3.00		
118.01	List amounts of malpractice premiums and paid losses:	198,283	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
	Transplant Center Information					
125.00	Does this facility operate a 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 center, 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 center, 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 center, 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 center, enter the certification date in column 1 and termination date, if applicable, in column 2.					129.00

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		1.00	2.00	
130.00	If this is a Medicare certified pancreas transplant center, 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 center, 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 center, 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 an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N		140.00

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

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

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

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

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

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

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

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

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		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: 15-1305 | Period: From 10/01/2021 To 09/30/2022 | Worksheet S-2 Part II | Date/Time Prepared: 2/23/2023 4:28 pm

			Y/N	Date	
			1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
	COMPLETED BY ALL HOSPITALS				
	Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)		N		1.00
		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00
		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
			Y/N	Legal Oper.	
			1.00	2.00	
	Approved Educational Activities				
6.00	Column 1: Are costs claimed for a nursing program? Column 2: If yes, is the provider is 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 co-payments waived? If yes, see instructions.			N	14.00
	Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N	15.00

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	12/30/2022	Y	12/30/2022	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1305 | Period: From 10/01/2021 To 09/30/2022 | Worksheet S-2 Part II Date/Time Prepared: 2/23/2023 4:28 pm

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

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

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

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?	N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			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.	MICHAEL	ALESSANDRINI	41.00
42.00	Enter the employer/company name of the cost report preparer.	BLUE AND CO., LLC		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317.713.7959	MALESSANDRINI@BLUEANDCO.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-1305	Period: From 10/01/2021 To 09/30/2022	Worksheet S-2 Part II Date/Time Prepared: 2/23/2023 4:28 pm

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1305 | Period: From 10/01/2021 To 09/30/2022 | Worksheet S-3 Part I | Date/Time Prepared: 2/23/2023 4:28 pm

	Component	Worksheet A Line Number	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	
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	25	9,125	26,088.00	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)		25	9,125	26,088.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	0	0	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		25	9,125	26,088.00	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	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	116.00	0	0			24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	88.00				0	26.00
26.01	RURAL HEALTH CLINIC II	88.01				0	26.01
26.02	RURAL HEALTH CLINIC III	88.02				0	26.02
26.03	RURAL HEALTH CLINIC IV	88.03				0	26.03
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		25				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1305 | Period: From 10/01/2021 To 09/30/2022 | Worksheet S-3 Part I | Date/Time Prepared: 2/23/2023 4:28 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
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)	485	7	1,087			1.00
2.00	HMO and other (see instructions)	140	56				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	287	0	287			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	333			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	772	7	1,707			7.00
8.00	INTENSIVE CARE UNIT	0	0	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		0	23			13.00
14.00	Total (see instructions)	772	7	1,730	0.00	176.24	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	0	0	0	0.00	0.00	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0	0	0	0.00	0.00	24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	4,757	244	21,840	0.00	47.82	26.00
26.01	RURAL HEALTH CLINIC II	1,784	16	4,904	0.00	4.44	26.01
26.02	RURAL HEALTH CLINIC III	304	12	1,261	0.00	2.95	26.02
26.03	RURAL HEALTH CLINIC IV	1,070	19	3,716	0.00	4.97	26.03
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	236.42	27.00
28.00	Observation Bed Days		32	536			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	10			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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1305 | Period: From 10/01/2021 To 09/30/2022 | Worksheet S-3 Part I | Date/Time Prepared: 2/23/2023 4:28 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
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	124	1	278	1.00
2.00	HMO and other (see instructions)			33	13		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	124	1	278	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	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0.00					24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0.00					26.00
26.01	RURAL HEALTH CLINIC II	0.00					26.01
26.02	RURAL HEALTH CLINIC III	0.00					26.02
26.03	RURAL HEALTH CLINIC IV	0.00					26.03
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-1305 | Component CCN: 15-8512 | Period: From 10/01/2021 To 09/30/2022 | Worksheet S-8 | Date/Time Prepared: 2/23/2023 4:28 pm

RHC I | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			540 HOSPITAL DRIVE		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	WINIMAC		IN	46996-	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

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

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

		Provider name	CCN number	
		1.00	2.00	
14.00	RHC/FQHC name, CCN number			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		PULASKI				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	08:00	19:00	08:00	19:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA	Provider CCN: 15-1305 Component CCN: 15-8512	Period: From 10/01/2021 To 09/30/2022	Worksheet S-8 Date/Time Prepared: 2/23/2023 4:28 pm
		RHC I	Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	08:00	16:30	08:00	12:00		11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-1305 | Component CCN: 15-8527 | Period: From 10/01/2021 To 09/30/2022 | Worksheet S-8 | Date/Time Prepared: 2/23/2023 4:28 pm

RHC II | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			NORTH LANE STREET		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	NORTH JUDSON		IN	46366-1226	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

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

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

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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA	Provider CCN: 15-1305 Component CCN: 15-8527	Period: From 10/01/2021 To 09/30/2022	Worksheet S-8 Date/Time Prepared: 2/23/2023 4:28 pm
		RHC II	Cost

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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-1305 | Component CCN: 15-8528 | Period: From 10/01/2021 To 09/30/2022 | Worksheet S-8 | Date/Time Prepared: 2/23/2023 4:28 pm

RHC III | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			112 E MONTGOMERY STREET		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	FRANCESVILLE		IN	47946-8087	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	09:00	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 number	
		1.00	2.00	
14.00	RHC/FQHC name, CCN number			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		PULASKI				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	19:00	08:00	16:00	08:00	16:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA	Provider CCN: 15-1305 Component CCN: 15-8528	Period: From 10/01/2021 To 09/30/2022	Worksheet S-8 Date/Time Prepared: 2/23/2023 4:28 pm
		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						11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-1305 | Component CCN: 15-8554 | Period: From 10/01/2021 To 09/30/2022 | Worksheet S-8 | Date/Time Prepared: 2/23/2023 4:28 pm

RHC IV | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			2 S. PEARL STREET		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	KNOX		IN	46534	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	19:00	08:00	11.00

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

		Provider name	CCN number	
		1.00	2.00	
14.00	RHC/FQHC name, CCN number			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						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	19:00	08:00	19:00	08:00	19:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 15-1305
Component CCN: 15-8554

Period:
From 10/01/2021
To 09/30/2022

Worksheet S-8
Date/Time Prepared:
2/23/2023 4:28 pm

RHC IV

Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	08:00	16:00	08:00	12:00		11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-1305 | Period: From 10/01/2021 To 09/30/2022 | Worksheet S-10 | Date/Time Prepared: 2/23/2023 4:28 pm

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.496129	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	1,153,864	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	235,830	5.00
6.00	Medicaid charges	10,011,625	6.00
7.00	Medicaid cost (line 1 times line 6)	4,967,057	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)	3,577,363	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)	3,577,363	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)	35,571	137,721	173,292	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	17,648	137,721	155,369	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)	17,648	137,721	155,369	23.00

		1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	1,002,849	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	137,499	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	211,536	27.01
28.00	Non-Medicare bad debt expense (see instructions)	791,313	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	466,630	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	621,999	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	4,199,362	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1305 | Period: From 10/01/2021 To 09/30/2022 | Worksheet A | Date/Time Prepared: 2/23/2023 4:28 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		1,693,515	1,693,515	46,058	1,739,573	1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	4,676,696	4,676,696	0	4,676,696	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,384,118	3,955,729	7,339,847	76,619	7,416,466	5.00
7.00	00700	OPERATION OF PLANT	425,905	611,628	1,037,533	0	1,037,533	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	9,522	69,455	78,977	0	78,977	8.00
9.00	00900	HOUSEKEEPING	209,477	137,263	346,740	0	346,740	9.00
10.00	01000	DIETARY	223,188	165,845	389,033	0	389,033	10.00
13.00	01300	NURSING ADMINISTRATION	373,141	242,857	615,998	0	615,998	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	20,629	93,073	113,702	0	113,702	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	315,721	43,134	358,855	0	358,855	16.00
17.00	01700	SOCIAL SERVICE	40,864	164	41,028	0	41,028	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,921,184	218,122	2,139,306	162,301	2,301,607	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	2,162	2,077	4,239	10,307	14,546	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	610,892	99,799	710,691	845,312	1,556,003	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	12,201	4,379	16,580	12,883	29,463	52.00
53.00	05300	ANESTHESIOLOGY	0	510,424	510,424	0	510,424	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	899,754	572,524	1,472,278	0	1,472,278	54.00
60.00	06000	LABORATORY	739,084	731,170	1,470,254	0	1,470,254	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	45,364	45,364	0	45,364	63.00
65.00	06500	RESPIRATORY THERAPY	365,491	45,006	410,497	0	410,497	65.00
66.00	06600	PHYSICAL THERAPY	967,349	42,859	1,010,208	0	1,010,208	66.00
67.00	06700	OCCUPATIONAL THERAPY	183,585	891	184,476	0	184,476	67.00
68.00	06800	SPEECH PATHOLOGY	120	45	165	0	165	68.00
69.00	06900	ELECTROCARDIOLOGY	0	13,195	13,195	0	13,195	69.00
69.01	06901	CARDIAC REHABILITATION	71,063	2,517	73,580	0	73,580	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	582,033	582,033	-124,149	457,884	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	124,149	124,149	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	81,628	2,159,905	2,241,533	0	2,241,533	73.00
76.00	03020	ONCOLOGY	146,674	34,062	180,736	0	180,736	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	5,262,581	437,912	5,700,493	-1,375,839	4,324,654	88.00
88.01	08801	RURAL HEALTH CLINIC II	684,728	110,359	795,087	117,761	912,848	88.01
88.02	08802	RURAL HEALTH CLINIC III	206,240	29,788	236,028	56,461	292,489	88.02
88.03	08803	RURAL HEALTH CLINIC IV	555,918	78,299	634,217	84,093	718,310	88.03
90.00	09000	CLINIC	61,862	238,249	300,111	0	300,111	90.00
91.00	09100	EMERGENCY	1,214,721	1,368,544	2,583,265	0	2,583,265	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	18,989,802	19,016,882	38,006,684	35,956	38,042,640	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	HOMECARE	0	0	0	0	0	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	333,176	64,377	397,553	0	397,553	192.00
192.01	19201	KNOX RHC	0	0	0	0	0	192.01
194.00	07950	MARKETING	81,041	158,664	239,705	-35,956	203,749	194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	19,404,019	19,239,923	38,643,942	0	38,643,942	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1305 | Period: From 10/01/2021 To 09/30/2022 | Worksheet A | Date/Time Prepared: 2/23/2023 4:28 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	-12,338	1,727,235		1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	4,676,696		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-1,406,772	6,009,694		5.00
7.00	00700	OPERATION OF PLANT	-278	1,037,255		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	78,977		8.00
9.00	00900	HOUSEKEEPING	0	346,740		9.00
10.00	01000	DIETARY	-54,903	334,130		10.00
13.00	01300	NURSING ADMINISTRATION	0	615,998		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-3,916	109,786		14.00
15.00	01500	PHARMACY	0	0		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-5,762	353,093		16.00
17.00	01700	SOCIAL SERVICE	0	41,028		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-579,403	1,722,204		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0		31.00
43.00	04300	NURSERY	0	14,546		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-990,980	565,023		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	29,463		52.00
53.00	05300	ANESTHESIOLOGY	-500,000	10,424		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,472,278		54.00
60.00	06000	LABORATORY	0	1,470,254		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	45,364		63.00
65.00	06500	RESPIRATORY THERAPY	0	410,497		65.00
66.00	06600	PHYSICAL THERAPY	0	1,010,208		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	184,476		67.00
68.00	06800	SPEECH PATHOLOGY	0	165		68.00
69.00	06900	ELECTROCARDIOLOGY	-4,294	8,901		69.00
69.01	06901	CARDIAC REHABILITATION	0	73,580		69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	-1	457,883		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	124,149		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,241,533		73.00
76.00	03020	ONCOLOGY	-30,000	150,736		76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	4,324,654		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	912,848		88.01
88.02	08802	RURAL HEALTH CLINIC III	0	292,489		88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	718,310		88.03
90.00	09000	CLINIC	0	300,111		90.00
91.00	09100	EMERGENCY	0	2,583,265		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	0		101.00
		SPECIAL PURPOSE COST CENTERS				
116.00	11600	HOSPICE	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-3,588,647	34,453,993		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
190.01	19001	HOMECARE	0	0		190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	397,553		192.00
192.01	19201	KNOX RHC	0	0		192.01
194.00	07950	MARKETING	0	203,749		194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-3,588,647	35,055,295		200.00

RECLASSIFICATIONS | Provider CCN: 15-1305 | Period: From 10/01/2021 To 09/30/2022 | Worksheet A-6 | Date/Time Prepared: 2/23/2023 4:28 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - PROPERTY INSURANCE RECLASS					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	46,058		1.00
	0		0	46,058		
	B - MARKETING RECLASS					
1.00	ADMINISTRATIVE & GENERAL	5.00	12,156	23,800		1.00
	0		12,156	23,800		
	C - IMPLANTABLE DEVICE RECLASS					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	124,149		1.00
	0		0	124,149		
	D - PHYSICIAN SALARIES RECLASS					
1.00	ADULTS & PEDIATRICS	30.00	185,491	0		1.00
2.00	OPERATING ROOM	50.00	845,312	0		2.00
3.00	RURAL HEALTH CLINIC II	88.01	75,666	0		3.00
4.00	RURAL HEALTH CLINIC III	88.02	44,288	0		4.00
5.00	RURAL HEALTH CLINIC IV	88.03	48,222	0		5.00
	0		1,198,979	0		
	E - PATIENT ACCOUNTS RECLASS					
1.00	ADMINISTRATIVE & GENERAL	5.00	86,721	0		1.00
	0		86,721	0		
	F - RHC DEPT 175 RECLASS					
1.00	RURAL HEALTH CLINIC II	88.01	0	47,339		1.00
2.00	RURAL HEALTH CLINIC III	88.02	0	12,173		2.00
3.00	RURAL HEALTH CLINIC IV	88.03	0	35,871		3.00
	0		0	95,383		
	G - RN SALARIES RECLASS					
1.00	NURSERY	43.00	10,307	0		1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	12,883	0		2.00
	0		23,190	0		
500.00	Grand Total: Increases		1,321,046	289,390		500.00

RECLASSIFICATIONS | Provider CCN: 15-1305 | Period: From 10/01/2021 To 09/30/2022 | Worksheet A-6 | Date/Time Prepared: 2/23/2023 4:28 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - PROPERTY INSURANCE RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	46,058	12		1.00
	0		0	46,058			
	B - MARKETING RECLASS						
1.00	MARKETING	194.00	12,156	23,800	0		1.00
	0		12,156	23,800			
	C - IMPLANTABLE DEVICE RECLASS						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	124,149	0		1.00
	0		0	124,149			
	D - PHYSICIAN SALARIES RECLASS						
1.00	RURAL HEALTH CLINIC	88.00	1,193,735	0	0		1.00
2.00	RURAL HEALTH CLINIC II	88.01	5,244	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
	0		1,198,979	0			
	E - PATIENT ACCOUNTS RECLASS						
1.00	RURAL HEALTH CLINIC	88.00	86,721	0	0		1.00
	0		86,721	0			
	F - RHC DEPT 175 RECLASS						
1.00	RURAL HEALTH CLINIC	88.00	0	95,383	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	0		0	95,383			
	G - RN SALARIES RECLASS						
1.00	ADULTS & PEDIATRICS	30.00	23,190	0	0		1.00
2.00		0.00	0	0	0		2.00
	0		23,190	0			
500.00	Grand Total: Decreases		1,321,046	289,390			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1305 | Period: From 10/01/2021 To 09/30/2022 | Worksheet A-7 Part I | Date/Time Prepared: 2/23/2023 4:28 pm

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	195,525	0	0	0	0	1.00
2.00	Land Improvements	432,594	0	0	0	0	2.00
3.00	Buildings and Fixtures	13,253,038	0	0	0	0	3.00
4.00	Building Improvements	187,055	0	0	0	0	4.00
5.00	Fixed Equipment	7,468,798	79,265	0	79,265	0	5.00
6.00	Movable Equipment	12,398,914	3,153,346	0	3,153,346	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	33,935,924	3,232,611	0	3,232,611	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	33,935,924	3,232,611	0	3,232,611	0	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	195,525	0	1.00
2.00	Land Improvements	432,594	0	2.00
3.00	Buildings and Fixtures	13,253,038	0	3.00
4.00	Building Improvements	187,055	0	4.00
5.00	Fixed Equipment	7,548,063	0	5.00
6.00	Movable Equipment	15,552,260	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	37,168,535	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	37,168,535	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1305 | Period: From 10/01/2021 To 09/30/2022 | Worksheet A-7 Part II | Date/Time Prepared: 2/23/2023 4:28 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1,372,053	0	321,462	0	0	1.00
3.00	Total (sum of lines 1-2)	1,372,053	0	321,462	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL			
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)		
		14.00	15.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2				
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	1,693,515		1.00
3.00	Total (sum of lines 1-2)	0	1,693,515		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1305 | Period: From 10/01/2021 To 09/30/2022 | Worksheet A-7 Part III | Date/Time Prepared: 2/23/2023 4:28 pm

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	37,168,535	0	37,168,535	1.000000	0	1.00
3.00	Total (sum of lines 1-2)	37,168,535	0	37,168,535	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	1,371,320	0	1.00
3.00	Total (sum of lines 1-2)	0	0	0	1,371,320	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	309,857	46,058	0	0	1,727,235	1.00
3.00	Total (sum of lines 1-2)	309,857	46,058	0	0	1,727,235	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1305 | Period: From 10/01/2021 To 09/30/2022 | Worksheet A-8 | Date/Time Prepared: 2/23/2023 4:28 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	*** Cost Center Deleted ***	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-1,604,677			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests		0		0.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	*** Cost Center Deleted ***	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1305 | Period: From 10/01/2021 To 09/30/2022 | Worksheet A-8 | Date/Time Prepared: 2/23/2023 4:28 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
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	INVEST INC/UNRESTRIC- INT EXP	B	-11,605	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	33.00
33.01	OTHER SERVICES -OTHER REV	B	-33,454	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02	CAFETERIA VENDING - OTHER REV	B	-54,903	DIETARY	10.00	0	33.02
33.03	REBATES & REFUNDS - OTHER REV	B	-3,916	CENTRAL SERVICES & SUPPLY	14.00	0	33.03
33.04	MEDICAL RECORDS FEES -OTHER REV	B	-5,762	MEDICAL RECORDS & LIBRARY	16.00	0	33.04
33.05	MED SUPPLY SALES -OTHER REV	B	-1	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	33.05
33.08	TELEVISION	A	-278	OPERATION OF PLANT	7.00	0	33.08
33.09	PHYSICIAN RECRUITMENT- ADMIN	A	-25,444	ADMINISTRATIVE & GENERAL	5.00	0	33.09
33.10	LOBBYING EXPENSE	A	-3,636	ADMINISTRATIVE & GENERAL	5.00	0	33.10
33.11	CRNA	A	-500,000	ANESTHESIOLOGY	53.00	0	33.11
33.12	HAF EXPENSE	A	-1,344,238	ADMINISTRATIVE & GENERAL	5.00	0	33.12
33.13	EHR DEPRECIATION ON 2012 PAYMENT	A	-733	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	33.13
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-3,588,647				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: 15-1305 | Period: From 10/01/2021 To 09/30/2022 | Worksheet A-8-2 | Date/Time Prepared: 2/23/2023 4:28 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	579,403	579,403	0	0	0	1.00
2.00	50.00	OPERATING ROOM	990,980	990,980	0	0	0	2.00
3.00	60.00	LABORATORY	5,957	0	5,957	0	0	3.00
4.00	69.00	ELECTROCARDIOLOGY	4,294	4,294	0	0	0	4.00
5.00	76.00	ONCOLOGY	30,000	30,000	0	0	0	5.00
6.00	90.00	CLINIC	34,400	0	34,400	0	0	6.00
7.00	91.00	EMERGENCY	1,251,744	0	1,251,744	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			2,896,778	1,604,677	1,292,101		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	50.00	OPERATING ROOM	0	0	0	0	0	2.00
3.00	60.00	LABORATORY	0	0	0	0	0	3.00
4.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	4.00
5.00	76.00	ONCOLOGY	0	0	0	0	0	5.00
6.00	90.00	CLINIC	0	0	0	0	0	6.00
7.00	91.00	EMERGENCY	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	579,403		1.00
2.00	50.00	OPERATING ROOM	0	0	0	990,980		2.00
3.00	60.00	LABORATORY	0	0	0	0		3.00
4.00	69.00	ELECTROCARDIOLOGY	0	0	0	4,294		4.00
5.00	76.00	ONCOLOGY	0	0	0	30,000		5.00
6.00	90.00	CLINIC	0	0	0	0		6.00
7.00	91.00	EMERGENCY	0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	1,604,677		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1305 | Period: From 10/01/2021 To 09/30/2022 | Worksheet B Part I | Date/Time Prepared: 2/23/2023 4:28 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS NEW BLDG & FIXT	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
			0	1.00	4.00	4A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	1,727,235	1,727,235				1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4,676,696	21,336	4,698,032			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	6,009,694	317,327	843,289	7,170,310	7,170,310	5.00
7.00	00700	OPERATION OF PLANT	1,037,255	153,041	103,118	1,293,414	332,587	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	78,977	14,913	2,305	96,195	24,735	8.00
9.00	00900	HOUSEKEEPING	346,740	9,179	50,718	406,637	104,562	9.00
10.00	01000	DIETARY	334,130	74,761	54,037	462,928	119,037	10.00
13.00	01300	NURSING ADMINISTRATION	615,998	11,000	90,343	717,341	184,456	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	109,786	23,255	4,995	138,036	35,494	14.00
15.00	01500	PHARMACY	0	19,072	0	19,072	4,904	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	353,093	37,971	76,441	467,505	120,214	16.00
17.00	01700	SOCIAL SERVICE	41,028	0	9,894	50,922	13,094	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,722,204	227,434	504,445	2,454,083	631,040	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	14,546	3,962	3,019	21,527	5,535	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	565,023	130,525	352,570	1,048,118	269,512	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	29,463	2,658	6,073	38,194	9,821	52.00
53.00	05300	ANESTHESIOLOGY	10,424	763	0	11,187	2,877	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,472,278	118,442	217,845	1,808,565	465,053	54.00
60.00	06000	LABORATORY	1,470,254	34,181	178,944	1,683,379	432,862	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	45,364	1,501	0	46,865	12,051	63.00
65.00	06500	RESPIRATORY THERAPY	410,497	19,269	88,491	518,257	133,264	65.00
66.00	06600	PHYSICAL THERAPY	1,010,208	43,533	234,211	1,287,952	331,183	66.00
67.00	06700	OCCUPATIONAL THERAPY	184,476	0	44,449	228,925	58,866	67.00
68.00	06800	SPEECH PATHOLOGY	165	0	29	194	50	68.00
69.00	06900	ELECTROCARDIOLOGY	8,901	0	0	8,901	2,289	69.00
69.01	06901	CARDIAC REHABILITATION	73,580	11,025	17,205	101,810	26,179	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	457,883	0	0	457,883	117,740	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	124,149	0	0	124,149	31,924	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,241,533	0	19,763	2,261,296	581,467	73.00
76.00	03020	ONCOLOGY	150,736	13,879	35,512	200,127	51,460	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	4,324,654	251,993	964,147	5,540,794	1,424,747	88.00
88.01	08801	RURAL HEALTH CLINIC II	912,848	0	182,834	1,095,682	281,743	88.01
88.02	08802	RURAL HEALTH CLINIC III	292,489	0	60,657	353,146	90,808	88.02
88.03	08803	RURAL HEALTH CLINIC IV	718,310	0	146,272	864,582	222,318	88.03
90.00	09000	CLINIC	300,111	44,665	14,978	359,754	92,507	90.00
91.00	09100	EMERGENCY	2,583,265	130,451	294,103	3,007,819	773,428	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	34,453,993	1,716,136	4,600,687	34,345,549	6,987,807	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	11,099	0	11,099	2,854	190.00
190.01	19001	HOMECARE	0	0	0	0	0	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	397,553	0	80,667	478,220	122,969	192.00
192.01	19201	KNOX RHC	0	0	0	0	0	192.01
194.00	07950	MARKETING	203,749	0	16,678	220,427	56,680	194.00
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	35,055,295	1,727,235	4,698,032	35,055,295	7,170,310	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1305 | Period: From 10/01/2021 To 09/30/2022 | Worksheet B Part I | Date/Time Prepared: 2/23/2023 4:28 pm

		Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	NURSING ADMINISTRATION	
			7.00	8.00	9.00	10.00	13.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	1,626,001					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	15,204	136,134				8.00
9.00	00900	HOUSEKEEPING	9,358	0	520,557			9.00
10.00	01000	DIETARY	76,220	0	25,599	683,784		10.00
13.00	01300	NURSING ADMINISTRATION	11,215	0	3,767	0	916,779	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	23,709	0	7,963	0	0	14.00
15.00	01500	PHARMACY	19,444	0	6,530	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	38,712	0	13,002	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	231,870	29,458	77,875	683,784	517,331	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	4,039	592	1,357	0	4,127	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	133,071	30,622	44,693	0	115,628	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,710	0	910	0	4,244	52.00
53.00	05300	ANESTHESIOLOGY	778	0	261	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	120,752	20,676	40,556	0	0	54.00
60.00	06000	LABORATORY	34,848	320	11,704	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	1,530	0	514	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	19,644	0	6,598	0	21,835	65.00
66.00	06600	PHYSICAL THERAPY	59,310	24,102	19,920	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 REHABILITATION	11,240	0	3,775	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	ONCOLOGY	14,150	27	4,752	0	38,868	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	256,908	2,298	86,283	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	97,946	438	32,896	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	41,196	0	13,836	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	53,966	0	18,125	0	0	88.03
90.00	09000	CLINIC	45,536	0	15,294	0	20,777	90.00
91.00	09100	EMERGENCY	132,995	26,893	44,668	0	193,969	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,456,351	135,426	480,878	683,784	916,779	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	11,315	0	3,800	0	0	190.00
190.01	19001	HOMECARE	0	0	0	0	0	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	158,335	708	35,879	0	0	192.00
192.01	19201	KNOX RHC	0	0	0	0	0	192.01
194.00	07950	MARKETING	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,626,001	136,134	520,557	683,784	916,779	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1305 | Period: From 10/01/2021 To 09/30/2022 | Worksheet B Part I | Date/Time Prepared: 2/23/2023 4:28 pm

		Cost Center Description	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	
			14.00	15.00	16.00	17.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	205,202					14.00
15.00	01500	PHARMACY	0	49,950				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	639,433			16.00
17.00	01700	SOCIAL SERVICE	0	0	0	64,016		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	17,026	59,743	4,702,210	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	0	0	152	0	37,329	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	56,251	4,273	1,702,168	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	769	0	56,648	52.00
53.00	05300	ANESTHESIOLOGY	0	0	7,560	0	22,663	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	143,429	0	2,599,031	54.00
60.00	06000	LABORATORY	0	0	128,181	0	2,291,294	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	1,653	0	62,613	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	6,045	0	705,643	65.00
66.00	06600	PHYSICAL THERAPY	0	0	27,693	0	1,750,160	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	5,515	0	293,306	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	52	0	296	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	5,911	0	17,101	69.00
69.01	06901	CARDIAC REHABILITATION	0	0	2,526	0	145,530	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	176,600	0	28,913	0	781,136	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	28,602	0	4,683	0	189,358	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	49,950	84,196	0	2,976,909	73.00
76.00	03020	ONCOLOGY	0	0	3,644	0	313,028	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	43,440	0	7,354,470	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	6,514	0	1,515,219	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	1,571	0	500,557	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	5,190	0	1,164,181	88.03
90.00	09000	CLINIC	0	0	3,508	0	537,376	90.00
91.00	09100	EMERGENCY	0	0	55,011	0	4,234,783	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	205,202	49,950	639,433	64,016	33,953,009	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	29,068	190.00
190.01	19001	HOMECARE	0	0	0	0	0	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	796,111	192.00
192.01	19201	KNOX RHC	0	0	0	0	0	192.01
194.00	07950	MARKETING	0	0	0	0	277,107	194.00
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	205,202	49,950	639,433	64,016	35,055,295	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1305 | Period: From 10/01/2021 To 09/30/2022 | Worksheet B Part I | Date/Time Prepared: 2/23/2023 4:28 pm

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE				17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	4,702,210		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0		31.00
43.00	04300	NURSERY	0	37,329		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	1,702,168		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	56,648		52.00
53.00	05300	ANESTHESIOLOGY	0	22,663		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,599,031		54.00
60.00	06000	LABORATORY	0	2,291,294		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	62,613		63.00
65.00	06500	RESPIRATORY THERAPY	0	705,643		65.00
66.00	06600	PHYSICAL THERAPY	0	1,750,160		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	293,306		67.00
68.00	06800	SPEECH PATHOLOGY	0	296		68.00
69.00	06900	ELECTROCARDIOLOGY	0	17,101		69.00
69.01	06901	CARDIAC REHABILITATION	0	145,530		69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	781,136		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	189,358		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,976,909		73.00
76.00	03020	ONCOLOGY	0	313,028		76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	7,354,470		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	1,515,219		88.01
88.02	08802	RURAL HEALTH CLINIC III	0	500,557		88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	1,164,181		88.03
90.00	09000	CLINIC	0	537,376		90.00
91.00	09100	EMERGENCY	0	4,234,783		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0			92.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	0		101.00
		SPECIAL PURPOSE COST CENTERS				
116.00	11600	HOSPICE	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	33,953,009		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	29,068		190.00
190.01	19001	HOMECARE	0	0		190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	796,111		192.00
192.01	19201	KNOX RHC	0	0		192.01
194.00	07950	MARKETING	0	277,107		194.00
200.00		Cross Foot Adjustments	0	0		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	0	35,055,295		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1305 | Period: From 10/01/2021 To 09/30/2022 | Worksheet B Part II Date/Time Prepared: 2/23/2023 4:28 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	
			0	1.00	2A	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	21,336	21,336	21,336		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	317,327	317,327	3,831	321,158	5.00
7.00	00700	OPERATION OF PLANT	0	153,041	153,041	468	14,896	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	14,913	14,913	10	1,108	8.00
9.00	00900	HOUSEKEEPING	0	9,179	9,179	230	4,683	9.00
10.00	01000	DIETARY	0	74,761	74,761	246	5,332	10.00
13.00	01300	NURSING ADMINISTRATION	0	11,000	11,000	410	8,262	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	23,255	23,255	23	1,590	14.00
15.00	01500	PHARMACY	0	19,072	19,072	0	220	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	37,971	37,971	347	5,384	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	45	586	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	227,434	227,434	2,292	28,264	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	0	3,962	3,962	14	248	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	130,525	130,525	1,602	12,071	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	2,658	2,658	28	440	52.00
53.00	05300	ANESTHESIOLOGY	0	763	763	0	129	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	118,442	118,442	990	20,829	54.00
60.00	06000	LABORATORY	0	34,181	34,181	813	19,387	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	1,501	1,501	0	540	63.00
65.00	06500	RESPIRATORY THERAPY	0	19,269	19,269	402	5,969	65.00
66.00	06600	PHYSICAL THERAPY	0	43,533	43,533	1,064	14,833	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	202	2,637	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	2	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	103	69.00
69.01	06901	CARDIAC REHABILITATION	0	11,025	11,025	78	1,173	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	5,273	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	1,430	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	90	26,043	73.00
76.00	03020	ONCOLOGY	0	13,879	13,879	161	2,305	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	251,993	251,993	4,372	63,819	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	831	12,619	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	276	4,067	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	665	9,957	88.03
90.00	09000	CLINIC	0	44,665	44,665	68	4,143	90.00
91.00	09100	EMERGENCY	0	130,451	130,451	1,336	34,641	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	1,716,136	1,716,136	20,894	312,983	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	11,099	11,099	0	128	190.00
190.01	19001	HOMECARE	0	0	0	0	0	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	366	5,508	192.00
192.01	19201	KNOX RHC	0	0	0	0	0	192.01
194.00	07950	MARKETING	0	0	0	76	2,539	194.00
200.00		Cross Foot Adjustments			0			200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	1,727,235	1,727,235	21,336	321,158	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1305 | Period: From 10/01/2021 To 09/30/2022 | Worksheet B Part II Date/Time Prepared: 2/23/2023 4:28 pm

		Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	NURSING ADMINISTRATION	
			7.00	8.00	9.00	10.00	13.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	168,405					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,575	17,606				8.00
9.00	00900	HOUSEKEEPING	969	0	15,061			9.00
10.00	01000	DIETARY	7,894	0	741	88,974		10.00
13.00	01300	NURSING ADMINISTRATION	1,162	0	109	0	20,943	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,456	0	230	0	0	14.00
15.00	01500	PHARMACY	2,014	0	189	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,009	0	376	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	24,015	3,810	2,253	88,974	11,818	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	418	77	39	0	94	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	13,782	3,959	1,293	0	2,641	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	281	0	26	0	97	52.00
53.00	05300	ANESTHESIOLOGY	81	0	8	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,506	2,674	1,173	0	0	54.00
60.00	06000	LABORATORY	3,609	41	339	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	159	0	15	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	2,035	0	191	0	499	65.00
66.00	06600	PHYSICAL THERAPY	6,143	3,117	576	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 REHABILITATION	1,164	0	109	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	ONCOLOGY	1,466	4	137	0	888	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	26,606	297	2,499	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	10,144	57	952	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	4,267	0	400	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	5,589	0	524	0	0	88.03
90.00	09000	CLINIC	4,716	0	442	0	475	90.00
91.00	09100	EMERGENCY	13,774	3,478	1,292	0	4,431	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	150,834	17,514	13,913	88,974	20,943	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,172	0	110	0	0	190.00
190.01	19001	HOMECARE	0	0	0	0	0	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	16,399	92	1,038	0	0	192.00
192.01	19201	KNOX RHC	0	0	0	0	0	192.01
194.00	07950	MARKETING	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	168,405	17,606	15,061	88,974	20,943	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1305 | Period: From 10/01/2021 To 09/30/2022 | Worksheet B Part II | Date/Time Prepared: 2/23/2023 4:28 pm

		Cost Center Description	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	
			14.00	15.00	16.00	17.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	27,554					14.00
15.00	01500	PHARMACY	0	21,495				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	48,087			16.00
17.00	01700	SOCIAL SERVICE	0	0	0	631		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	1,281	589	390,730	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	0	0	11	0	4,863	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	4,232	42	170,147	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	58	0	3,588	52.00
53.00	05300	ANESTHESIOLOGY	0	0	569	0	1,550	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	10,771	0	167,385	54.00
60.00	06000	LABORATORY	0	0	9,644	0	68,014	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	124	0	2,339	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	455	0	28,820	65.00
66.00	06600	PHYSICAL THERAPY	0	0	2,083	0	71,349	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	415	0	3,254	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	4	0	6	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	445	0	548	69.00
69.01	06901	CARDIAC REHABILITATION	0	0	190	0	13,739	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	23,713	0	2,175	0	31,161	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,841	0	352	0	5,623	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	21,495	6,335	0	53,963	73.00
76.00	03020	ONCOLOGY	0	0	274	0	19,114	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	3,268	0	352,854	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	490	0	25,093	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	118	0	9,128	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	390	0	17,125	88.03
90.00	09000	CLINIC	0	0	264	0	54,773	90.00
91.00	09100	EMERGENCY	0	0	4,139	0	193,542	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	27,554	21,495	48,087	631	1,688,708	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	12,509	190.00
190.01	19001	HOMECARE	0	0	0	0	0	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	23,403	192.00
192.01	19201	KNOX RHC	0	0	0	0	0	192.01
194.00	07950	MARKETING	0	0	0	0	2,615	194.00
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	27,554	21,495	48,087	631	1,727,235	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1305 | Period: From 10/01/2021 To 09/30/2022 | Worksheet B Part II | Date/Time Prepared: 2/23/2023 4:28 pm

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE				17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	390,730		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0		31.00
43.00	04300	NURSERY	0	4,863		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	170,147		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	3,588		52.00
53.00	05300	ANESTHESIOLOGY	0	1,550		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	167,385		54.00
60.00	06000	LABORATORY	0	68,014		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	2,339		63.00
65.00	06500	RESPIRATORY THERAPY	0	28,820		65.00
66.00	06600	PHYSICAL THERAPY	0	71,349		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	3,254		67.00
68.00	06800	SPEECH PATHOLOGY	0	6		68.00
69.00	06900	ELECTROCARDIOLOGY	0	548		69.00
69.01	06901	CARDIAC REHABILITATION	0	13,739		69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	31,161		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	5,623		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	53,963		73.00
76.00	03020	ONCOLOGY	0	19,114		76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	352,854		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	25,093		88.01
88.02	08802	RURAL HEALTH CLINIC III	0	9,128		88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	17,125		88.03
90.00	09000	CLINIC	0	54,773		90.00
91.00	09100	EMERGENCY	0	193,542		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0			92.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	0		101.00
		SPECIAL PURPOSE COST CENTERS				
116.00	11600	HOSPICE	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	1,688,708		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	12,509		190.00
190.01	19001	HOMECARE	0	0		190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	23,403		192.00
192.01	19201	KNOX RHC	0	0		192.01
194.00	07950	MARKETING	0	2,615		194.00
200.00		Cross Foot Adjustments	0	0		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	0	1,727,235		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1305 | Period: From 10/01/2021 To 09/30/2022 | Worksheet B-1 | Date/Time Prepared: 2/23/2023 4:28 pm

		Cost Center Description	CAPITAL RELATED COSTS NEW BLDG & FIXT (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
			1.00	4.00	5A	5.00	7.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	70,188					1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	867	19,404,019				4.00
5.00	00500	ADMINISTRATIVE & GENERAL	12,895	3,482,995	-7,170,310	27,884,985		5.00
7.00	00700	OPERATION OF PLANT	6,219	425,905	0	1,293,414	64,810	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	606	9,522	0	96,195	606	8.00
9.00	00900	HOUSEKEEPING	373	209,477	0	406,637	373	9.00
10.00	01000	DIETARY	3,038	223,188	0	462,928	3,038	10.00
13.00	01300	NURSING ADMINISTRATION	447	373,141	0	717,341	447	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	945	20,629	0	138,036	945	14.00
15.00	01500	PHARMACY	775	0	0	19,072	775	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,543	315,721	0	467,505	1,543	16.00
17.00	01700	SOCIAL SERVICE	0	40,864	0	50,922	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,242	2,083,485	0	2,454,083	9,242	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	161	12,469	0	21,527	161	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,304	1,456,204	0	1,048,118	5,304	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	108	25,084	0	38,194	108	52.00
53.00	05300	ANESTHESIOLOGY	31	0	0	11,187	31	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,813	899,754	0	1,808,565	4,813	54.00
60.00	06000	LABORATORY	1,389	739,084	0	1,683,379	1,389	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	61	0	0	46,865	61	63.00
65.00	06500	RESPIRATORY THERAPY	783	365,491	0	518,257	783	65.00
66.00	06600	PHYSICAL THERAPY	1,769	967,349	0	1,287,952	2,364	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	183,585	0	228,925	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	120	0	194	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	8,901	0	69.00
69.01	06901	CARDIAC REHABILITATION	448	71,063	0	101,810	448	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	457,883	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	124,149	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	81,628	0	2,261,296	0	73.00
76.00	03020	ONCOLOGY	564	146,674	0	200,127	564	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	10,240	3,982,125	0	5,540,794	10,240	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	755,150	0	1,095,682	3,904	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	250,528	0	353,146	1,642	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	604,140	0	864,582	2,151	88.03
90.00	09000	CLINIC	1,815	61,862	0	359,754	1,815	90.00
91.00	09100	EMERGENCY	5,301	1,214,721	0	3,007,819	5,301	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	69,737	19,001,958	-7,170,310	27,175,239	58,048	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	451	0	0	11,099	451	190.00
190.01	19001	HOMECARE	0	0	0	0	0	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	333,176	0	478,220	6,311	192.00
192.01	19201	KNOX RHC	0	0	0	0	0	192.01
194.00	07950	MARKETING	0	68,885	0	220,427	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,727,235	4,698,032		7,170,310	1,626,001	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	24.608694	0.242116		0.257139	25.088736	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		21,336		321,158	168,405	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.001100		0.011517	2.598442	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: 15-1305 | Period: From 10/01/2021 To 09/30/2022 | Worksheet B-1 | Date/Time Prepared: 2/23/2023 4:28 pm

		Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (100%)	
			8.00	9.00	10.00	13.00	14.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE	99,537					8.00
9.00	00900	HOUSEKEEPING	0	61,778				9.00
10.00	01000	DIETARY	0	3,038	100			10.00
13.00	01300	NURSING ADMINISTRATION	0	447	0	78,851		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	945	0	0	3,595,470	14.00
15.00	01500	PHARMACY	0	775	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,543	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	21,539	9,242	100	44,495	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	433	161	0	355	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	22,389	5,304	0	9,945	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	108	0	365	0	52.00
53.00	05300	ANESTHESIOLOGY	0	31	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	15,118	4,813	0	0	0	54.00
60.00	06000	LABORATORY	234	1,389	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	61	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	783	0	1,878	0	65.00
66.00	06600	PHYSICAL THERAPY	17,623	2,364	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 REHABILITATION	0	448	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	3,094,308	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	501,162	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	ONCOLOGY	20	564	0	3,343	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,680	10,240	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	320	3,904	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	1,642	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	2,151	0	0	0	88.03
90.00	09000	CLINIC	0	1,815	0	1,787	0	90.00
91.00	09100	EMERGENCY	19,663	5,301	0	16,683	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	99,019	57,069	100	78,851	3,595,470	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	451	0	0	0	190.00
190.01	19001	HOMECARE	0	0	0	0	0	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	518	4,258	0	0	0	192.00
192.01	19201	KNOX RHC	0	0	0	0	0	192.01
194.00	07950	MARKETING	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	136,134	520,557	683,784	916,779	205,202	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	1.367672	8.426252	6,837.840000	11.626726	0.057072	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	17,606	15,061	88,974	20,943	27,554	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.176879	0.243792	889.740000	0.265602	0.007664	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: 15-1305 | Period: From 10/01/2021 To 09/30/2022 | Worksheet B-1 | Date/Time Prepared: 2/23/2023 4:28 pm

		Cost Center Description	PHARMACY (100%)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (ALLOCATION OF TIME)		
			15.00	16.00	17.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY	100				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	68,435,904			16.00
17.00	01700	SOCIAL SERVICE	0	0	9,888		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	1,822,080	9,228		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0		31.00
43.00	04300	NURSERY	0	16,275	0		43.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	6,020,045	660		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	82,348	0		52.00
53.00	05300	ANESTHESIOLOGY	0	809,070	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	15,353,051	0		54.00
60.00	06000	LABORATORY	0	13,718,049	0		60.00
60.01	06001	BLOOD LABORATORY	0	0	0		60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	176,855	0		63.00
65.00	06500	RESPIRATORY THERAPY	0	646,961	0		65.00
66.00	06600	PHYSICAL THERAPY	0	2,963,720	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	590,270	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	5,573	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	632,637	0		69.00
69.01	06901	CARDIAC REHABILITATION	0	270,372	0		69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,094,308	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	501,162	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	100	9,010,703	0		73.00
76.00	03020	ONCOLOGY	0	389,973	0		76.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	4,649,023	0		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	697,170	0		88.01
88.02	08802	RURAL HEALTH CLINIC III	0	168,149	0		88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	555,385	0		88.03
90.00	09000	CLINIC	0	375,448	0		90.00
91.00	09100	EMERGENCY	0	5,887,277	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
		OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	0	0	0		101.00
		SPECIAL PURPOSE COST CENTERS					
116.00	11600	HOSPICE	0	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	100	68,435,904	9,888		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		190.00
190.01	19001	HOMECARE	0	0	0		190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0		192.00
192.01	19201	KNOX RHC	0	0	0		192.01
194.00	07950	MARKETING	0	0	0		194.00
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	49,950	639,433	64,016		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	499.500000	0.009344	6.474110		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	21,495	48,087	631		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	214.950000	0.000703	0.063815		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: 15-1305 | Period: From 10/01/2021 To 09/30/2022 | Worksheet C Part I Date/Time Prepared: 2/23/2023 4:28 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,702,210		4,702,210	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0		0	0	0	31.00
43.00	04300	NURSERY	37,329		37,329	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,702,168		1,702,168	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	56,648		56,648	0	0	52.00
53.00	05300	ANESTHESIOLOGY	22,663		22,663	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,599,031		2,599,031	0	0	54.00
60.00	06000	LABORATORY	2,291,294		2,291,294	0	0	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	62,613		62,613	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	705,643	0	705,643	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,750,160	0	1,750,160	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	293,306	0	293,306	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	296	0	296	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	17,101		17,101	0	0	69.00
69.01	06901	CARDIAC REHABILITATION	145,530		145,530	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	781,136		781,136	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	189,358		189,358	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,976,909		2,976,909	0	0	73.00
76.00	03020	ONCOLOGY	313,028		313,028	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	7,354,470		7,354,470	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	1,515,219		1,515,219	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	500,557		500,557	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	1,164,181		1,164,181	0	0	88.03
90.00	09000	CLINIC	537,376		537,376	0	0	90.00
91.00	09100	EMERGENCY	4,234,783		4,234,783	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,297,978		1,297,978		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0		0		0	116.00
200.00		Subtotal (see instructions)	35,250,987	0	35,250,987	0	0	200.00
201.00		Less Observation Beds	1,297,978		1,297,978		0	201.00
202.00		Total (see instructions)	33,953,009	0	33,953,009	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1305 | Period: From 10/01/2021 To 09/30/2022 | Worksheet C Part I Date/Time Prepared: 2/23/2023 4:28 pm

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	1,364,429		1,364,429			30.00
31.00	03100	INTENSIVE CARE UNIT	0		0			31.00
43.00	04300	NURSERY	16,275		16,275			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	725,910	5,294,135	6,020,045	0.282750	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	66,197	16,151	82,348	0.687910	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	65,121	743,949	809,070	0.028011	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	973,890	14,379,161	15,353,051	0.169284	0.000000	54.00
60.00	06000	LABORATORY	1,727,227	11,990,822	13,718,049	0.167028	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	61,656	115,199	176,855	0.354036	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	263,072	383,889	646,961	1.090704	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	391,381	2,572,339	2,963,720	0.590528	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	206,508	383,762	590,270	0.496901	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	4,795	778	5,573	0.053113	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	25,940	606,697	632,637	0.027031	0.000000	69.00
69.01	06901	CARDIAC REHABILITATION	0	270,372	270,372	0.538258	0.000000	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,187,125	1,907,183	3,094,308	0.252443	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	113,405	387,757	501,162	0.377838	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,664,072	4,346,631	9,010,703	0.330375	0.000000	73.00
76.00	03020	ONCOLOGY	2,417	387,556	389,973	0.802691	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	4,649,023	4,649,023			88.00
88.01	08801	RURAL HEALTH CLINIC II	0	697,170	697,170			88.01
88.02	08802	RURAL HEALTH CLINIC III	0	168,149	168,149			88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	555,385	555,385			88.03
90.00	09000	CLINIC	0	375,448	375,448	1.431293	0.000000	90.00
91.00	09100	EMERGENCY	262,626	5,624,651	5,887,277	0.719311	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	4,000	453,651	457,651	2.836174	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0			116.00
200.00		Subtotal (see instructions)	12,126,046	56,309,858	68,435,904			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	12,126,046	56,309,858	68,435,904			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1305 | Period: From 10/01/2021 To 09/30/2022 | Worksheet C Part I Date/Time Prepared: 2/23/2023 4:28 pm

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
43.00	04300	NURSERY		43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
60.00	06000	LABORATORY	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0.000000	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	63.00
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 REHABILITATION	0.000000	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
76.00	03020	ONCOLOGY	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC		88.00
88.01	08801	RURAL HEALTH CLINIC II		88.01
88.02	08802	RURAL HEALTH CLINIC III		88.02
88.03	08803	RURAL HEALTH CLINIC IV		88.03
90.00	09000	CLINIC	0.000000	90.00
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS		
101.00	10100	HOME HEALTH AGENCY		101.00
		SPECIAL PURPOSE COST CENTERS		
116.00	11600	HOSPICE		116.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1305 | Period: From 10/01/2021 To 09/30/2022 | Worksheet C Part I Date/Time Prepared: 2/23/2023 4:28 pm

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	4,702,210		4,702,210	0	4,702,210	30.00
31.00	03100	INTENSIVE CARE UNIT	0		0	0	0	31.00
43.00	04300	NURSERY	37,329		37,329	0	37,329	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,702,168		1,702,168	0	1,702,168	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	56,648		56,648	0	56,648	52.00
53.00	05300	ANESTHESIOLOGY	22,663		22,663	0	22,663	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,599,031		2,599,031	0	2,599,031	54.00
60.00	06000	LABORATORY	2,291,294		2,291,294	0	2,291,294	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	62,613		62,613	0	62,613	63.00
65.00	06500	RESPIRATORY THERAPY	705,643	0	705,643	0	705,643	65.00
66.00	06600	PHYSICAL THERAPY	1,750,160	0	1,750,160	0	1,750,160	66.00
67.00	06700	OCCUPATIONAL THERAPY	293,306	0	293,306	0	293,306	67.00
68.00	06800	SPEECH PATHOLOGY	296	0	296	0	296	68.00
69.00	06900	ELECTROCARDIOLOGY	17,101		17,101	0	17,101	69.00
69.01	06901	CARDIAC REHABILITATION	145,530		145,530	0	145,530	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	781,136		781,136	0	781,136	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	189,358		189,358	0	189,358	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,976,909		2,976,909	0	2,976,909	73.00
76.00	03020	ONCOLOGY	313,028		313,028	0	313,028	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	7,354,470		7,354,470	0	7,354,470	88.00
88.01	08801	RURAL HEALTH CLINIC II	1,515,219		1,515,219	0	1,515,219	88.01
88.02	08802	RURAL HEALTH CLINIC III	500,557		500,557	0	500,557	88.02
88.03	08803	RURAL HEALTH CLINIC IV	1,164,181		1,164,181	0	1,164,181	88.03
90.00	09000	CLINIC	537,376		537,376	0	537,376	90.00
91.00	09100	EMERGENCY	4,234,783		4,234,783	0	4,234,783	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,297,978		1,297,978		1,297,978	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0		0		0	116.00
200.00		Subtotal (see instructions)	35,250,987	0	35,250,987	0	35,250,987	200.00
201.00		Less Observation Beds	1,297,978		1,297,978		1,297,978	201.00
202.00		Total (see instructions)	33,953,009	0	33,953,009	0	33,953,009	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1305 | Period: From 10/01/2021 To 09/30/2022 | Worksheet C Part I Date/Time Prepared: 2/23/2023 4:28 pm

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	1,364,429		1,364,429			30.00
31.00	03100	INTENSIVE CARE UNIT	0		0			31.00
43.00	04300	NURSERY	16,275		16,275			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	725,910	5,294,135	6,020,045	0.282750	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	66,197	16,151	82,348	0.687910	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	65,121	743,949	809,070	0.028011	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	973,890	14,379,161	15,353,051	0.169284	0.000000	54.00
60.00	06000	LABORATORY	1,727,227	11,990,822	13,718,049	0.167028	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	61,656	115,199	176,855	0.354036	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	263,072	383,889	646,961	1.090704	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	391,381	2,572,339	2,963,720	0.590528	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	206,508	383,762	590,270	0.496901	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	4,795	778	5,573	0.053113	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	25,940	606,697	632,637	0.027031	0.000000	69.00
69.01	06901	CARDIAC REHABILITATION	0	270,372	270,372	0.538258	0.000000	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,187,125	1,907,183	3,094,308	0.252443	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	113,405	387,757	501,162	0.377838	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,664,072	4,346,631	9,010,703	0.330375	0.000000	73.00
76.00	03020	ONCOLOGY	2,417	387,556	389,973	0.802691	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	4,649,023	4,649,023	1.581939	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	697,170	697,170	2.173385	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	168,149	168,149	2.976866	0.000000	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	555,385	555,385	2.096169	0.000000	88.03
90.00	09000	CLINIC	0	375,448	375,448	1.431293	0.000000	90.00
91.00	09100	EMERGENCY	262,626	5,624,651	5,887,277	0.719311	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	4,000	453,651	457,651	2.836174	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0			116.00
200.00		Subtotal (see instructions)	12,126,046	56,309,858	68,435,904			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	12,126,046	56,309,858	68,435,904			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1305 | Period: From 10/01/2021 To 09/30/2022 | Worksheet C Part I Date/Time Prepared: 2/23/2023 4:28 pm

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
43.00	04300	NURSERY		43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
60.00	06000	LABORATORY	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0.000000	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	63.00
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 REHABILITATION	0.000000	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
76.00	03020	ONCOLOGY	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0.000000	88.03
90.00	09000	CLINIC	0.000000	90.00
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS		
101.00	10100	HOME HEALTH AGENCY		101.00
		SPECIAL PURPOSE COST CENTERS		
116.00	11600	HOSPICE		116.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-1305 | Period: From 10/01/2021 To 09/30/2022 | Worksheet D Part II Date/Time Prepared: 2/23/2023 4:28 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	170,147	6,020,045	0.028263	241,408	6,823	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,588	82,348	0.043571	0	0	52.00
53.00	05300	ANESTHESIOLOGY	1,550	809,070	0.001916	23,547	45	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	167,385	15,353,051	0.010902	201,739	2,199	54.00
60.00	06000	LABORATORY	68,014	13,718,049	0.004958	327,330	1,623	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	2,339	176,855	0.013226	13,750	182	63.00
65.00	06500	RESPIRATORY THERAPY	28,820	646,961	0.044547	90,718	4,041	65.00
66.00	06600	PHYSICAL THERAPY	71,349	2,963,720	0.024074	65,111	1,567	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,254	590,270	0.005513	33,629	185	67.00
68.00	06800	SPEECH PATHOLOGY	6	5,573	0.001077	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	548	632,637	0.000866	13,576	12	69.00
69.01	06901	CARDIAC REHABILITATION	13,739	270,372	0.050815	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	31,161	3,094,308	0.010070	365,495	3,681	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,623	501,162	0.011220	62,247	698	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	53,963	9,010,703	0.005989	487,445	2,919	73.00
76.00	03020	ONCOLOGY	19,114	389,973	0.049014	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	352,854	4,649,023	0.075899	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	25,093	697,170	0.035993	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	9,128	168,149	0.054285	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	17,125	555,385	0.030834	0	0	88.03
90.00	09000	CLINIC	54,773	375,448	0.145887	0	0	90.00
91.00	09100	EMERGENCY	193,542	5,887,277	0.032875	28,193	927	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	107,855	457,651	0.235671	3,689	869	92.00
200.00		Total (lines 50 through 199)	1,400,970	67,055,200		1,957,877	25,771	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1305 | Period: From 10/01/2021 To 09/30/2022 | Worksheet D Part IV | Date/Time Prepared: 2/23/2023 4:28 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
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 REHABILITATION	0	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	ONCOLOGY	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	0	0	88.03
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
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: 15-1305 | Period: From 10/01/2021 To 09/30/2022 | Worksheet D Part IV Date/Time Prepared: 2/23/2023 4:28 pm

Title XVIII | Hospital | Cost

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	6,020,045	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	82,348	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	809,070	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	15,353,051	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	13,718,049	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0.000000	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	176,855	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	646,961	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,963,720	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	590,270	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	5,573	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	632,637	0.000000	69.00
69.01	06901	CARDIAC REHABILITATION	0	0	0	270,372	0.000000	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	3,094,308	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	501,162	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	9,010,703	0.000000	73.00
76.00	03020	ONCOLOGY	0	0	0	389,973	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	4,649,023	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	697,170	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	168,149	0.000000	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	555,385	0.000000	88.03
90.00	09000	CLINIC	0	0	0	375,448	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	5,887,277	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	457,651	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	67,055,200		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1305 | Period: From 10/01/2021 To 09/30/2022 | Worksheet D Part IV Date/Time Prepared: 2/23/2023 4:28 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	241,408	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	23,547	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	201,739	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	327,330	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	13,750	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.000000	90,718	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	65,111	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	33,629	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	13,576	0	0	0	69.00
69.01	06901	CARDIAC REHABILITATION	0.000000	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	365,495	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	62,247	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	487,445	0	0	0	73.00
76.00	03020	ONCOLOGY	0.000000	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000	0	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0.000000	0	0	0	0	88.03
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	28,193	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	3,689	0	0	0	92.00
200.00		Total (lines 50 through 199)		1,957,877	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1305 | Period: From 10/01/2021 To 09/30/2022 | Worksheet D Part V Date/Time Prepared: 2/23/2023 4:28 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.282750	0	1,370,458	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.687910	0	578	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.028011	0	193,091	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.169284	0	4,001,802	0	0	54.00
60.00	06000	LABORATORY	0.167028	0	3,851,580	0	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.354036	0	58,208	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	1.090704	0	91,855	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.590528	0	916,559	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.496901	0	110,053	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.053113	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.027031	0	182,736	0	0	69.00
69.01	06901	CARDIAC REHABILITATION	0.538258	0	94,484	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.252443	0	711,037	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.377838	0	85,328	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.330375	0	3,375,040	420	0	73.00
76.00	03020	ONCOLOGY	0.802691	0	199,312	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC						88.00
88.01	08801	RURAL HEALTH CLINIC II						88.01
88.02	08802	RURAL HEALTH CLINIC III						88.02
88.03	08803	RURAL HEALTH CLINIC IV						88.03
90.00	09000	CLINIC	1.431293	0	251,659	0	0	90.00
91.00	09100	EMERGENCY	0.719311	0	1,288,769	64,466	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2.836174	0	146,945	0	0	92.00
200.00		Subtotal (see instructions)		0	16,929,494	64,886	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	16,929,494	64,886	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1305 | Period: From 10/01/2021 To 09/30/2022 | Worksheet D Part V Date/Time Prepared: 2/23/2023 4:28 pm

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	387,497	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	398	0		52.00
53.00	05300	ANESTHESIOLOGY	5,409	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	677,441	0		54.00
60.00	06000	LABORATORY	643,322	0		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	20,608	0		63.00
65.00	06500	RESPIRATORY THERAPY	100,187	0		65.00
66.00	06600	PHYSICAL THERAPY	541,254	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	54,685	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	4,940	0		69.00
69.01	06901	CARDIAC REHABILITATION	50,857	0		69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	179,496	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	32,240	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,115,029	139		73.00
76.00	03020	ONCOLOGY	159,986	0		76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC				88.00
88.01	08801	RURAL HEALTH CLINIC II				88.01
88.02	08802	RURAL HEALTH CLINIC III				88.02
88.03	08803	RURAL HEALTH CLINIC IV				88.03
90.00	09000	CLINIC	360,198	0		90.00
91.00	09100	EMERGENCY	927,026	46,371		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	416,762	0		92.00
200.00		Subtotal (see instructions)	5,677,335	46,510		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	5,677,335	46,510		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1305 | Period: From 10/01/2021 To 09/30/2022 | Worksheet D-1 | Date/Time Prepared: 2/23/2023 4:28 pm

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,243	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,623	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)	1,087	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	90	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)	197	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	35	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)	298	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	485	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)	90	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)	197	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	231.10	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	231.10	20.00
21.00	Total general inpatient routine service cost (see instructions)	4,702,210	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)	8,089	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)	68,868	25.00
26.00	Total swing-bed cost (see instructions)	771,956	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,930,254	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)	3,930,254	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	2,421.60	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,174,476	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)	1,174,476	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1305 | Period: From 10/01/2021 To 09/30/2022 | Worksheet D-1 | Date/Time Prepared: 2/23/2023 4:28 pm

Title XVIII | Hospital | Cost

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	624,652	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	1,799,128	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
56.00	Target amount (line 54 x line 55)	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	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 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)	217,944	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	477,055	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	694,999	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)	536	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,421.60	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,297,978	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1305 | Period: From 10/01/2021 To 09/30/2022 | Worksheet D-1 | Date/Time Prepared: 2/23/2023 4:28 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	390,730	4,702,210	0.083095	1,297,978	107,855	90.00
91.00	Nursing Program cost	0	4,702,210	0.000000	1,297,978	0	91.00
92.00	Allied health cost	0	4,702,210	0.000000	1,297,978	0	92.00
93.00	All other Medical Education	0	4,702,210	0.000000	1,297,978	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1305 | Period: From 10/01/2021 To 09/30/2022 | Worksheet D-1 | Date/Time Prepared: 2/23/2023 4:28 pm

Title XIX | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,243	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,623	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)	1,087	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	287	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	35	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)	298	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	7	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)	23	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	231.10	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	231.10	20.00
21.00	Total general inpatient routine service cost (see instructions)	4,702,210	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)	8,089	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)	68,868	25.00
26.00	Total swing-bed cost (see instructions)	771,956	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,930,254	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)	3,930,254	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	2,421.60	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	16,951	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)	16,951	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1305 | Period: From 10/01/2021 To 09/30/2022 | Worksheet D-1 | Date/Time Prepared: 2/23/2023 4:28 pm

Title XIX | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	37,329	23	1,623.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	11,456	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	28,407	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
56.00	Target amount (line 54 x line 55)	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	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 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)	536	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,421.60	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,297,978	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1305 | Period: From 10/01/2021 To 09/30/2022 | Worksheet D-1 | Date/Time Prepared: 2/23/2023 4:28 pm

Title XIX | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	390,730	4,702,210	0.083095	1,297,978	107,855	90.00
91.00	Nursing Program cost	0	4,702,210	0.000000	1,297,978	0	91.00
92.00	Allied health cost	0	4,702,210	0.000000	1,297,978	0	92.00
93.00	All other Medical Education	0	4,702,210	0.000000	1,297,978	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1305 | Period: From 10/01/2021 To 09/30/2022 | Worksheet D-3 | Date/Time Prepared: 2/23/2023 4:28 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		496,687		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.282750	241,408	68,258	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.687910	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.028011	23,547	660	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.169284	201,739	34,151	54.00
60.00	06000	LABORATORY	0.167028	327,330	54,673	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.354036	13,750	4,868	63.00
65.00	06500	RESPIRATORY THERAPY	1.090704	90,718	98,946	65.00
66.00	06600	PHYSICAL THERAPY	0.590528	65,111	38,450	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.496901	33,629	16,710	67.00
68.00	06800	SPEECH PATHOLOGY	0.053113	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.027031	13,576	367	69.00
69.01	06901	CARDIAC REHABILITATION	0.538258	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.252443	365,495	92,267	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.377838	62,247	23,519	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.330375	487,445	161,040	73.00
76.00	03020	ONCOLOGY	0.802691	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000		0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0.000000		0	88.03
90.00	09000	CLINIC	1.431293	0	0	90.00
91.00	09100	EMERGENCY	0.719311	28,193	20,280	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2.836174	3,689	10,463	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,957,877	624,652	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		1,957,877		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-1305 | Period: From 10/01/2021 To 09/30/2022 | Worksheet D-3

Component CCN: 15-Z305 | Date/Time Prepared: 2/23/2023 4:28 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.282750	5,039	1,425	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.687910	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.028011	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.169284	19,255	3,260	54.00
60.00	06000	LABORATORY	0.167028	37,575	6,276	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.354036	1,819	644	63.00
65.00	06500	RESPIRATORY THERAPY	1.090704	26,867	29,304	65.00
66.00	06600	PHYSICAL THERAPY	0.590528	92,197	54,445	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.496901	57,441	28,542	67.00
68.00	06800	SPEECH PATHOLOGY	0.053113	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.027031	630	17	69.00
69.01	06901	CARDIAC REHABILITATION	0.538258	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.252443	48,261	12,183	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.377838	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.330375	84,466	27,905	73.00
76.00	03020	ONCOLOGY	0.802691	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000		0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0.000000		0	88.03
90.00	09000	CLINIC	1.431293	0	0	90.00
91.00	09100	EMERGENCY	0.719311	4,690	3,374	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2.836174	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		378,240	167,375	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)		378,240		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1305 | Period: From 10/01/2021 To 09/30/2022 | Worksheet D-3 | Date/Time Prepared: 2/23/2023 4:28 pm

Title XIX | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		3,436		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
43.00	04300	NURSERY		0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.282750	3,927	1,110	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.687910	1,561	1,074	52.00
53.00	05300	ANESTHESIOLOGY	0.028011	354	10	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.169284	2,338	396	54.00
60.00	06000	LABORATORY	0.167028	7,434	1,242	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.354036	128	45	63.00
65.00	06500	RESPIRATORY THERAPY	1.090704	1,020	1,113	65.00
66.00	06600	PHYSICAL THERAPY	0.590528	166	98	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.496901	95	47	67.00
68.00	06800	SPEECH PATHOLOGY	0.053113	88	5	68.00
69.00	06900	ELECTROCARDIOLOGY	0.027031	22	1	69.00
69.01	06901	CARDIAC REHABILITATION	0.538258	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.252443	2,263	571	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.377838	12,369	4,673	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.330375	0	0	73.00
76.00	03020	ONCOLOGY	0.802691	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	1.581939	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	2.173385	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	2.976866	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	2.096169	0	0	88.03
90.00	09000	CLINIC	1.431293	0	0	90.00
91.00	09100	EMERGENCY	0.719311	1,489	1,071	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2.836174	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		33,254	11,456	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)		33,254		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-1305 | Period: From 10/01/2021 To 09/30/2022 | Worksheet D-3

Component CCN: 15-Z305 | Date/Time Prepared: 2/23/2023 4:28 pm

Title XIX | Swing Beds - SNF | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.000000	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	0	0	54.00
60.00	06000	LABORATORY	0.000000	0	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
69.01	06901	CARDIAC REHABILITATION	0.000000	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	0	0	73.00
76.00	03020	ONCOLOGY	0.000000	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0.000000	0	0	88.03
90.00	09000	CLINIC	0.000000	0	0	90.00
91.00	09100	EMERGENCY	0.000000	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		0	0	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)		0		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-1305 | Period: From 10/01/2021 To 09/30/2022 | Worksheet E Part B Date/Time Prepared: 2/23/2023 4:28 pm

Title XVIII | Hospital | Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	5,723,845	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)	5,723,845	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)	5,781,083	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)	74,383	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	2,617,138	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	3,089,562	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	3,089,562	30.00
31.00	Primary payer payments	2,441	31.00
32.00	Subtotal (line 30 minus line 31)	3,087,121	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)	196,795	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	127,917	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	187,270	36.00
37.00	Subtotal (see instructions)	3,215,038	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
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	3,215,038	40.00
40.01	Sequestration adjustment (see instructions)	24,113	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		40.03
41.00	Interim payments	3,121,440	41.00
41.01	Interim payments-PARHM		41.01
42.00	Tentative settlement (for contractors use only)	0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)		42.01
43.00	Balance due provider/program (see instructions)	69,485	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: 15-1305	Period: From 10/01/2021 To 09/30/2022	Worksheet E Part B Date/Time Prepared: 2/23/2023 4:28 pm
	Title XVIII	Hospital	Cost

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Provider CCN: 15-1305 | Period: From 10/01/2021 To 09/30/2022 | Worksheet E-1 Part I Date/Time Prepared: 2/23/2023 4:28 pm

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,669,901		3,067,840	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	04/12/2022	53,600	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		53,600	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,669,901		3,121,440	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		69,485	6.01
6.02	SETTLEMENT TO PROGRAM		81		0	6.02
7.00	Total Medicare program liability (see instructions)		1,669,820		3,190,925	7.00

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-1305 | Component CCN: 15-Z305 | Period: From 10/01/2021 To 09/30/2022 | Worksheet E-1 Part I | Date/Time Prepared: 2/23/2023 4:28 pm

Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		838,038		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)		838,038		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		22,165		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		860,203		0	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-1305	Period: From 10/01/2021 To 09/30/2022	Worksheet E-1 Part II Date/Time Prepared: 2/23/2023 4:28 pm
	Title XVIII	Hospital	Cost

		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14		1.00
2.00	Medicare days (Wkst. S-3, Pt. I, col. 6, sum of lines 1, and 8 through 12, and plus for cost reporting periods beginning on or after 10/01/2013, line 32)		2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2		3.00
4.00	Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of lines 1, and 8 through 12, and plus for cost reporting periods beginning on or after 10/01/2013, line 32)		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: 15-1305 | Component CCN: 15-Z305 | Period: From 10/01/2021 To 09/30/2022 | Worksheet E-2 | Date/Time Prepared: 2/23/2023 4:28 pm

Title XVIII | Swing Beds - SNF | Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	701,949	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)	169,049	0	3.00
3.01	Nursing and allied health payment-PARHM (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	287	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)	870,998	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	870,998	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	910	0	11.00
12.00	Subtotal (line 10 minus line 11)	870,088	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	3,384	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (see instructions)	866,704	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			16.50
16.55	Rural community hospital demonstration project (§410A Demonstration) payment adjustment (see instructions)	0		16.55
16.99	Demonstration payment adjustment amount before sequestration	0	0	16.99
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	866,704	0	19.00
19.01	Sequestration adjustment (see instructions)	6,501	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0	0	19.02
19.03	Sequestration adjustment-PARHM pass-throughs			19.03
19.25	Sequestration for non-claims based amounts (see instructions)	0	0	19.25
20.00	Interim payments	838,038	0	20.00
20.01	Interim payments-PARHM			20.01
21.00	Tentative settlement (for contractor use only)	0	0	21.00
21.01	Tentative settlement-PARHM (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)	22,165	0	22.00
22.01	Balance due provider/program-PARHM (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 - SWING BEDS | Provider CCN: 15-1305 | Component CCN: 15-Z305 | Period: From 10/01/2021 To 09/30/2022 | Worksheet E-2 | Date/Time Prepared: 2/23/2023 4:28 pm

Title XIX | Swing Beds - SNF | PPS

		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)	0		1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)	0		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)	0		3.00
3.01	Nursing and allied health payment-PARHM (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	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)	0		8.00
9.00	Primary payer payments (see instructions)	0		9.00
10.00	Subtotal (line 8 minus line 9)	0		10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0		11.00
12.00	Subtotal (line 10 minus line 11)	0		12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	0		13.00
14.00	80% of Part B costs (line 12 x 80%)	0		14.00
15.00	Subtotal (see instructions)	0		15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	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)			16.55
16.99	Demonstration payment adjustment amount before sequestration	0		16.99
17.00	Allowable bad debts (see instructions)	0		17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0		17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0		18.00
19.00	Total (see instructions)	0		19.00
19.01	Sequestration adjustment (see instructions)	0		19.01
19.02	Demonstration payment adjustment amount after sequestration)	0		19.02
19.03	Sequestration adjustment-PARHM pass-throughs			19.03
19.25	Sequestration for non-claims based amounts (see instructions)	0		19.25
20.00	Interim payments	0		20.00
20.01	Interim payments-PARHM			20.01
21.00	Tentative settlement (for contractor use only)	0		21.00
21.01	Tentative settlement-PARHM (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)	0		22.00
22.01	Balance due provider/program-PARHM (see instructions)			22.01
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	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: 15-1305	Period: From 10/01/2021 To 09/30/2022	Worksheet E-3 Part V Date/Time Prepared: 2/23/2023 4:28 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	1,799,128	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)	0	2.00
3.00	Organ acquisition	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	1,799,128	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	1,817,119	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	1,817,119	19.00
20.00	Deductibles (exclude professional component)	144,263	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	1,672,856	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	1,672,856	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	14,741	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	9,582	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	9,374	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	1,682,438	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29.98	Recovery of accelerated depreciation.	0	29.98
29.99	Demonstration payment adjustment amount before sequestration	0	29.99
30.00	Subtotal (see instructions)	1,682,438	30.00
30.01	Sequestration adjustment (see instructions)	12,618	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
30.03	Sequestration adjustment-PARHM		30.03
31.00	Interim payments	1,669,901	31.00
31.01	Interim payments-PARHM		31.01
32.00	Tentative settlement (for contractor use only)	0	32.00
32.01	Tentative settlement-PARHM (for contractor use only)		32.01
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)	-81	33.00
33.01	Balance due provider/program-PARHM (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: 15-1305 | Period: From 10/01/2021 To 09/30/2022 | Worksheet E-3 Part VII Date/Time Prepared: 2/23/2023 4:28 pm

Title XIX | Hospital | Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	28,407		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	28,407	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)	28,407	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	3,436		8.00
9.00	Ancillary service charges	33,254	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)	36,690	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)	36,690	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	8,283	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)	28,407	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)	28,407	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)	28,407	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)	28,407	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	28,407	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)	28,407	0	40.00
41.00	Interim payments	11,755	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	16,652	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: 15-1305 | Period: From 10/01/2021 To 09/30/2022 | Worksheet G | Date/Time Prepared: 2/23/2023 4:28 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	1,091,224	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	12,114,659	0	0	0	4.00
5.00	Other receivable	11,127	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-7,505,948	0	0	0	6.00
7.00	Inventory	691,039	0	0	0	7.00
8.00	Prepaid expenses	52,059	0	0	0	8.00
9.00	Other current assets	3,650,341	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)	10,104,501	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	195,525	0	0	0	12.00
13.00	Land improvements	432,594	0	0	0	13.00
14.00	Accumulated depreciation	-438,869	0	0	0	14.00
15.00	Buildings	13,253,038	0	0	0	15.00
16.00	Accumulated depreciation	-9,212,240	0	0	0	16.00
17.00	Leasehold improvements	187,055	0	0	0	17.00
18.00	Accumulated depreciation	-201,069	0	0	0	18.00
19.00	Fixed equipment	7,548,063	0	0	0	19.00
20.00	Accumulated depreciation	-7,074,063	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	15,552,260	0	0	0	23.00
24.00	Accumulated depreciation	-9,108,874	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)	11,133,420	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	14,191,949	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	14,191,949	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	35,429,870	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	863,247	0	0	0	37.00
38.00	Salaries, wages, and fees payable	2,249,783	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	866,952	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	892,921	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	4,872,903	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	6,374,997	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	-375,782	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	5,999,215	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	10,872,118	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	24,557,752				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)	24,557,752	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	35,429,870	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-1305 | Period: From 10/01/2021 To 09/30/2022 | Worksheet G-1 | Date/Time Prepared: 2/23/2023 4:28 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		22,193,346		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		2,364,406				2.00
3.00	Total (sum of line 1 and line 2)		24,557,752		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		24,557,752		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)		24,557,752		0		19.00

		Endowment Fund	Plant Fund		
		6.00	7.00	8.00	
1.00	Fund balances at beginning of period	0		0	1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)				2.00
3.00	Total (sum of line 1 and line 2)	0		0	3.00
4.00	Additions (credit adjustments) (specify)		0		4.00
5.00			0		5.00
6.00			0		6.00
7.00			0		7.00
8.00			0		8.00
9.00			0		9.00
10.00	Total additions (sum of line 4-9)	0		0	10.00
11.00	Subtotal (line 3 plus line 10)	0		0	11.00
12.00	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: 15-1305 | Period: From 10/01/2021 To 09/30/2022 | Worksheet G-2 Parts I & II Date/Time Prepared: 2/23/2023 4:28 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	1,537,945		1,537,945	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)	1,537,945		1,537,945	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	0		0	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)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	1,537,945		1,537,945	17.00
18.00	Ancillary services	10,174,316	43,933,540	54,107,856	18.00
19.00	Outpatient services	262,626	6,457,750	6,720,376	19.00
20.00	RURAL HEALTH CLINIC	0	4,649,023	4,649,023	20.00
20.01	RURAL HEALTH CLINIC II	0	697,170	697,170	20.01
20.02	RURAL HEALTH CLINIC III	0	168,149	168,149	20.02
20.03	RURAL HEALTH CLINIC IV	0	555,385	555,385	20.03
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		0	0	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	0	0	0	26.00
27.00	NON-PROVIDER BASED	0	117,917	117,917	27.00
27.01	PHYSICIAN FEES	316,141	328	316,469	27.01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	12,291,028	56,579,262	68,870,290	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		38,643,942		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		38,643,942		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-1305 | Period: From 10/01/2021 To 09/30/2022 | Worksheet G-3 | Date/Time Prepared: 2/23/2023 4:28 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	68,870,290	1.00
2.00	Less contractual allowances and discounts on patients' accounts	35,258,724	2.00
3.00	Net patient revenues (line 1 minus line 2)	33,611,566	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	38,643,942	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-5,032,376	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER INCOME	6,368,851	24.00
24.01	RENTAL INCOME	15,709	24.01
24.02	NON OPERATING	103,193	24.02
24.50	COVID-19 PHE Funding	909,029	24.50
25.00	Total other income (sum of lines 6-24)	7,396,782	25.00
26.00	Total (line 5 plus line 25)	2,364,406	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)	2,364,406	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1305 | Component CCN: 15-8512 | Period: From 10/01/2021 To 09/30/2022 | Worksheet M-1 | Date/Time Prepared: 2/23/2023 4:28 pm

RHC I | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	2,719,726	24,000	2,743,726	-1,178,488	1,565,238	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	1,074,993	48,000	1,122,993	-40,091	1,082,902	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	206,708	0	206,708	0	206,708	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	15,360	0	15,360	-7,932	7,428	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	709,713	0	709,713	0	709,713	9.00
10.00	Subtotal (sum of lines 1 through 9)	4,726,500	72,000	4,798,500	-1,226,511	3,571,989	10.00
11.00	Physician Services Under Agreement	0	0	0	-26,660	-26,660	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	-26,660	-26,660	14.00
15.00	Medical Supplies	0	44,034	44,034	-10,761	33,273	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	44,034	44,034	-10,761	33,273	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	4,726,500	116,034	4,842,534	-1,263,932	3,578,602	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	32,776	32,776	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	32,776	32,776	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	169,790	169,790	-52,126	117,664	29.00
30.00	Administrative Costs	536,081	152,087	688,168	-92,556	595,612	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	536,081	321,877	857,958	-144,682	713,276	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	5,262,581	437,911	5,700,492	-1,375,838	4,324,654	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1305 | Component CCN: 15-8512 | Period: From 10/01/2021 To 09/30/2022 | Worksheet M-1 | Date/Time Prepared: 2/23/2023 4:28 pm

RHC I | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	1,565,238		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	1,082,902		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	206,708		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	7,428		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	709,713		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	3,571,989		10.00
11.00	Physician Services Under Agreement	0	-26,660		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	-26,660		14.00
15.00	Medical Supplies	0	33,273		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	33,273		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	3,578,602		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	32,776		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	32,776		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	117,664		29.00
30.00	Administrative Costs	0	595,612		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	713,276		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	4,324,654		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1305
Component CCN: 15-8527
Period: From 10/01/2021 To 09/30/2022
Worksheet M-1
Date/Time Prepared: 2/23/2023 4:28 pm

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	447,048	36,000	483,048	69,874	552,922	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	22,694	7,200	29,894	-2,033	27,861	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	104,906	0	104,906	0	104,906	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	1,725	1,725	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	24,691	0	24,691	0	24,691	9.00
10.00	Subtotal (sum of lines 1 through 9)	599,339	43,200	642,539	69,566	712,105	10.00
11.00	Physician Services Under Agreement	0	0	0	13,231	13,231	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	13,231	13,231	14.00
15.00	Medical Supplies	0	12,960	12,960	5,341	18,301	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	12,960	12,960	5,341	18,301	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	599,339	56,160	655,499	88,138	743,637	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	856	856	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	856	856	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	33,680	33,680	25,871	59,551	29.00
30.00	Administrative Costs	85,389	20,519	105,908	2,896	108,804	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	85,389	54,199	139,588	28,767	168,355	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	684,728	110,359	795,087	117,761	912,848	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1305 | Component CCN: 15-8527 | Period: From 10/01/2021 To 09/30/2022 | Worksheet M-1 | Date/Time Prepared: 2/23/2023 4:28 pm

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	552,922		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	27,861		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	104,906		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	1,725		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	24,691		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	712,105		10.00
11.00	Physician Services Under Agreement	0	13,231		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	13,231		14.00
15.00	Medical Supplies	0	18,301		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	18,301		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	743,637		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	856		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	856		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	59,551		29.00
30.00	Administrative Costs	0	108,804		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	168,355		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	912,848		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1305 | Component CCN: 15-8528 | Period: From 10/01/2021 To 09/30/2022 | Worksheet M-1 | Date/Time Prepared: 2/23/2023 4:28 pm

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	0	0	0	42,777	42,777	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	122,620	12,000	134,620	-13,461	121,159	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	71,480	0	71,480	0	71,480	9.00
10.00	Subtotal (sum of lines 1 through 9)	194,100	12,000	206,100	29,316	235,416	10.00
11.00	Physician Services Under Agreement	0	0	0	3,402	3,402	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	3,402	3,402	14.00
15.00	Medical Supplies	0	4,220	4,220	1,373	5,593	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	4,220	4,220	1,373	5,593	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	194,100	16,220	210,320	34,091	244,411	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	14,972	14,972	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	14,972	14,972	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	5,855	5,855	6,652	12,507	29.00
30.00	Administrative Costs	12,140	7,714	19,854	745	20,599	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	12,140	13,569	25,709	7,397	33,106	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	206,240	29,789	236,029	56,460	292,489	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1305 | Component CCN: 15-8528 | Period: From 10/01/2021 To 09/30/2022 | Worksheet M-1 | Date/Time Prepared: 2/23/2023 4:28 pm

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	42,777		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	121,159		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	0		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	71,480		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	235,416		10.00
11.00	Physician Services Under Agreement	0	3,402		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	3,402		14.00
15.00	Medical Supplies	0	5,593		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	5,593		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	244,411		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	14,972		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	14,972		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	12,507		29.00
30.00	Administrative Costs	0	20,599		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	33,106		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	292,489		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1305
Component CCN: 15-8554

Period: From 10/01/2021 To 09/30/2022

Worksheet M-1
Date/Time Prepared: 2/23/2023 4:28 pm

RHC IV | 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	326,320	15,000	341,320	29,198	370,518	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	123,395	11,000	134,395	-13,549	120,846	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	73,822	0	73,822	0	73,822	9.00
10.00	Subtotal (sum of lines 1 through 9)	523,537	26,000	549,537	15,649	565,186	10.00
11.00	Physician Services Under Agreement	0	0	0	10,026	10,026	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	10,026	10,026	14.00
15.00	Medical Supplies	0	0	0	4,047	4,047	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	0	0	4,047	4,047	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	523,537	26,000	549,537	29,722	579,259	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	32,573	32,573	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	32,573	32,573	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	33,574	33,574	19,603	53,177	29.00
30.00	Administrative Costs	32,381	18,726	51,107	2,194	53,301	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	32,381	52,300	84,681	21,797	106,478	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	555,918	78,300	634,218	84,092	718,310	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1305 | Component CCN: 15-8554 | Period: From 10/01/2021 To 09/30/2022 | Worksheet M-1 | Date/Time Prepared: 2/23/2023 4:28 pm

RHC IV | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	370,518		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	120,846		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	0		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	73,822		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	565,186		10.00
11.00	Physician Services Under Agreement	0	10,026		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	10,026		14.00
15.00	Medical Supplies	0	4,047		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	4,047		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	579,259		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	32,573		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	32,573		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	53,177		29.00
30.00	Administrative Costs	0	53,301		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	106,478		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	718,310		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-1305 | Component CCN: 15-8512 | Period: From 10/01/2021 To 09/30/2022 | Worksheet M-2 | Date/Time Prepared: 2/23/2023 4:28 pm

RHC I | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	4.83	13,270	1	5		1.00
2.00	Physician Assistant	0.00	0	1	0		2.00
3.00	Nurse Practitioner	3.62	7,025	1	4		3.00
4.00	Subtotal (sum of lines 1 through 3)	8.45	20,295		9	20,295	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	1.05	1,545			1,545	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	9.50	21,840			21,840	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					3,578,602	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					32,776	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					3,611,378	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.990924	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					713,276	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					3,029,816	15.00
16.00	Total overhead (sum of lines 14 and 15)					3,743,092	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					3,743,092	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					3,709,120	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					7,287,722	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-1305 | Component CCN: 15-8527 | Period: From 10/01/2021 To 09/30/2022 | Worksheet M-2 | Date/Time Prepared: 2/23/2023 4:28 pm

RHC II | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.81	2,279	1	1		1.00
2.00	Physician Assistant	0.00	0	1	0		2.00
3.00	Nurse Practitioner	1.69	2,573	1	2		3.00
4.00	Subtotal (sum of lines 1 through 3)	2.50	4,852		3	4,852	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.03	52			52	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	2.53	4,904			4,904	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)					743,637	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					856	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					744,493	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.998850	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					168,355	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					602,371	15.00
16.00	Total overhead (sum of lines 14 and 15)					770,726	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					770,726	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					769,840	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					1,513,477	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-1305 | Component CCN: 15-8528 | Period: From 10/01/2021 To 09/30/2022 | Worksheet M-2 | Date/Time Prepared: 2/23/2023 4:28 pm

RHC III | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.05	144	1	0		1.00
2.00	Physician Assistant	0.00	0	1	0		2.00
3.00	Nurse Practitioner	0.57	1,117	1	1		3.00
4.00	Subtotal (sum of lines 1 through 3)	0.62	1,261		1	1,261	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	0.62	1,261			1,261	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)					244,411	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					14,972	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					259,383	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.942278	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					33,106	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					208,068	15.00
16.00	Total overhead (sum of lines 14 and 15)					241,174	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					241,174	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					227,253	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					471,664	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-1305 | Component CCN: 15-8554 | Period: From 10/01/2021 To 09/30/2022 | Worksheet M-2 | Date/Time Prepared: 2/23/2023 4:28 pm

RHC IV | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.90	1,876	1	1		1.00
2.00	Physician Assistant	0.00	0	1	0		2.00
3.00	Nurse Practitioner	0.81	1,840	1	1		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.71	3,716		2	3,716	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	1.71	3,716			3,716	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)					579,259	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					32,573	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					611,832	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.946762	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					106,478	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					445,871	15.00
16.00	Total overhead (sum of lines 14 and 15)					552,349	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					552,349	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					522,943	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					1,102,202	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 15-1305 Component CCN: 15-8512	Period: From 10/01/2021 To 09/30/2022	Worksheet M-3 Date/Time Prepared: 2/23/2023 4:28 pm
	Title XVIII	RHC I	Cost

			1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)		7,287,722	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)		96,013	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)		7,191,709	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		21,840	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)		21,840	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		329.29	7.00

		Calculation of Limit (1)		
		Rate Period 1 (10/01/2021 through 12/31/2021)	Rate Period 2 (01/01/2022 through 09/30/2022)	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	232.77	237.66	8.00
9.00	Rate for Program covered visits (see instructions)	232.77	237.66	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	1,229	3,503	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	286,074	832,523	11.00
12.00	Program covered visits for mental health services (from contractor records)	7	18	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	1,629	4,278	13.00
14.00	Limit adjustment for mental health services (see instructions)	1,629	4,278	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	1,124,504	16.00
16.01	Total program charges (see instructions)(from contractor's records)		628,562	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		23,460	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		41,970	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.)		788,544	16.04
16.05	Total program cost (see instructions)	0	830,514	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		96,854	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		101,650	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		830,514	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		36,363	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		866,877	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)		866,877	26.00
26.01	Sequestration adjustment (see instructions)		6,501	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		822,482	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)		37,894	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: 15-1305 Component CCN: 15-8527	Period: From 10/01/2021 To 09/30/2022	Worksheet M-3 Date/Time Prepared: 2/23/2023 4:28 pm
	Title XVIII	RHC II	Cost

				1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			1,513,477	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			37,800	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			1,475,677	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			4,904	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			0	5.00
6.00	Total adjusted visits (line 4 plus line 5)			4,904	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			300.91	7.00
		Calculation of Limit (1)			
		Rate Period 1 (10/01/2021 through 12/31/2021)	Rate Period 2 (01/01/2022 through 09/30/2022)		
		1.00	2.00		
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	188.36	192.32		8.00
9.00	Rate for Program covered visits (see instructions)	188.36	192.32		9.00
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	533	1,237		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	100,396	237,900		11.00
12.00	Program covered visits for mental health services (from contractor records)	0	14		12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	2,692		13.00
14.00	Limit adjustment for mental health services (see instructions)	0	2,692		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	340,988		16.00
16.01	Total program charges (see instructions)(from contractor's records)		215,671		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		10,265		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		16,230		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.)		230,230		16.04
16.05	Total program cost (see instructions)	0	246,460		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		36,971		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		33,687		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		246,460		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		15,738		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		262,198		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)		262,198		26.00
26.01	Sequestration adjustment (see instructions)		1,966		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		244,414		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)		15,818		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: 15-1305 Component CCN: 15-8528	Period: From 10/01/2021 To 09/30/2022	Worksheet M-3 Date/Time Prepared: 2/23/2023 4:28 pm
	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)			471,664	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			13,744	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			457,920	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			1,261	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)			1,261	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			363.14	7.00
		Calculation of Limit (1)			
		Rate Period 1 (10/01/2021 through 12/31/2021)	Rate Period 2 (01/01/2022 through 09/30/2022)		
		1.00	2.00		
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	306.89	313.33		8.00
9.00	Rate for Program covered visits (see instructions)	306.89	313.33		9.00
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	72	232		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	22,096	72,693		11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0		12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0		13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0		14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	94,789		16.00
16.01	Total program charges (see instructions)(from contractor's records)		37,875		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		5,172		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		12,944		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.)		60,968		16.04
16.05	Total program cost (see instructions)	0	73,912		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		5,635		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		5,414		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		73,912		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		8,822		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		82,734		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)		82,734		26.00
26.01	Sequestration adjustment (see instructions)		621		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		72,760		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)		9,353		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: 15-1305 Component CCN: 15-8554	Period: From 10/01/2021 To 09/30/2022	Worksheet M-3 Date/Time Prepared: 2/23/2023 4:28 pm
	Title XVIII	RHC IV	Cost

				1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			1,102,202	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			6,323	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			1,095,879	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			3,716	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)			3,716	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			294.91	7.00
		Calculation of Limit (1)			
		Rate Period 1 (10/01/2021 through 12/31/2021)	Rate Period 2 (01/01/2022 through 09/30/2022)		
		1.00	2.00		
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	203.35	207.62		8.00
9.00	Rate for Program covered visits (see instructions)	203.35	207.62		9.00
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	255	815		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	51,854	169,210		11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0		12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0		13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0		14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	221,064		16.00
16.01	Total program charges (see instructions)(from contractor's records)		136,971		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		9,996		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		16,133		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.)		148,919		16.04
16.05	Total program cost (see instructions)	0	165,052		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		18,782		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		21,639		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		165,052		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		1,715		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		166,767		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)		166,767		26.00
26.01	Sequestration adjustment (see instructions)		1,251		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		163,052		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)		2,464		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: 15-1305 | Component CCN: 15-8512 | Period: From 10/01/2021 To 09/30/2022 | Worksheet M-4 | Date/Time Prepared: 2/23/2023 4:28 pm

Title XVIII | RHC I | Cost

		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	3,571,989	3,571,989	3,571,989	3,571,989	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000365	0.001528	0.001832	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	1,304	5,458	6,544	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	18,313	15,527	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	19,617	20,985	6,544	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	3,578,602	3,578,602	3,578,602	3,578,602	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	3,709,120	3,709,120	3,709,120	3,709,120	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.005482	0.005864	0.001829	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	20,333	21,750	6,784	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	39,950	42,735	13,328	0	10.00
11.00	Total number of injections/infusions (from your records)	107	448	537	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	373.36	95.39	24.82	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	26	198	206	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			107	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)	9,707	18,887	7,769	0	14.00
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)		96,013			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)		36,363			16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 15-1305 | Component CCN: 15-8527 | Period: From 10/01/2021 To 09/30/2022 | Worksheet M-4 | Date/Time Prepared: 2/23/2023 4:28 pm

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)	712,105	712,105	712,105	712,105	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000938	0.006864	0.004102	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	668	4,888	2,921	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	5,644	4,452	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	6,312	9,340	2,921	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	743,637	743,637	743,637	743,637	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	769,840	769,840	769,840	769,840	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.008488	0.012560	0.003928	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	6,534	9,669	3,024	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	12,846	19,009	5,945	0	10.00
11.00	Total number of injections/infusions (from your records)	35	256	153	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	367.03	74.25	38.86	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	10	106	58	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			50	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	3,670	7,871	4,197	0	14.00
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)		37,800			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)		15,738			16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 15-1305 | Component CCN: 15-8528 | Period: From 10/01/2021 To 09/30/2022 | Worksheet M-4 | Date/Time Prepared: 2/23/2023 4:28 pm

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)	235,416	235,416	235,416	235,416	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.001656	0.004388	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	390	1,033	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	3,137	2,562	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	3,527	3,595	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	244,411	244,411	244,411	244,411	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	227,253	227,253	227,253	227,253	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.014431	0.014709	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	3,279	3,343	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	6,806	6,938	0	0	10.00
11.00	Total number of injections/infusions (from your records)	20	53	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	340.30	130.91	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	14	31	0	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	4,764	4,058	0	0	14.00
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)		13,744			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)		8,822			16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 15-1305 | Component CCN: 15-8554 | Period: From 10/01/2021 To 09/30/2022 | Worksheet M-4 | Date/Time Prepared: 2/23/2023 4:28 pm

Title XVIII | RHC IV | 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)	565,186	565,186	565,186	565,186	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000031	0.002179	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	18	1,232	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	105	1,968	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	123	3,200	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	579,259	579,259	579,259	579,259	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	522,943	522,943	522,943	522,943	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.000212	0.005524	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	111	2,889	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	234	6,089	0	0	10.00
11.00	Total number of injections/infusions (from your records)	1	71	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	234.00	85.76	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	0	20	0	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	0	1,715	0	0	14.00
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)		6,323			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)		1,715			16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 15-1305 Component CCN: 15-8512	Period: From 10/01/2021 To 09/30/2022	Worksheet M-5 Date/Time Prepared: 2/23/2023 4:28 pm
		RHC I	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		822,482	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)		822,482	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		37,894	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		860,376	7.00

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

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 15-1305 Component CCN: 15-8527	Period: From 10/01/2021 To 09/30/2022	Worksheet M-5 Date/Time Prepared: 2/23/2023 4:28 pm
		RHC II	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		244,414	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)		244,414	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		15,818	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		260,232	7.00

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

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 15-1305 Component CCN: 15-8528	Period: From 10/01/2021 To 09/30/2022	Worksheet M-5 Date/Time Prepared: 2/23/2023 4:28 pm

		RHC III	Cost	
		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		72,760	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)		72,760	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		9,353	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		82,113	7.00

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

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 15-1305 Component CCN: 15-8554	Period: From 10/01/2021 To 09/30/2022	Worksheet M-5 Date/Time Prepared: 2/23/2023 4:28 pm
		RHC IV	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		163,052	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)		163,052	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		2,464	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		165,516	7.00

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