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: 15-0115	Period: From 07/01/2021 To 06/30/2022	Worksheet S Parts I-III Date/Time Prepared: 11/29/2022 11:30 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 11/29/2022 Time: 11:30 am
2. [ ] Manually prepared cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full 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 MEMORIAL HOSP & HEALTH CARE CTR (15-0115) for the cost reporting period beginning 07/01/2021 and ending 06/30/2022 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				I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name				2
3	Signatory Title				3
4	Date				4

	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	1,207,284	-72,142	0	0	1.00
2.00	Subprovider - IPF	0	12,776	0		0	2.00
3.00	Subprovider - IRF	0	-22,654	0		0	3.00
5.00	Swing Bed - SNF	0	0	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7.00
9.00	HOME HEALTH AGENCY I	0	0	-1		0	9.00
10.00	RURAL HEALTH CLINIC I	0		13,131		0	10.00
10.01	RURAL HEALTH CLINIC II	0		16,123		0	10.01
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11.00
200.00	Total	0	1,197,406	-42,889	0	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0115 | Period: From 07/01/2021 To 06/30/2022 | Worksheet S-2 Part I Date/Time Prepared: 11/29/2022 11:30 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 800 WEST 9TH STREET	PO Box:			1.00
2.00	City: JASPER	State: IN	Zip Code: 47546	County: DUBOIS	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	MEMORIAL HOSP & HEALTH CARE CTR	150115	99915	1	07/01/1966	N	P	O	3.00
4.00	Subprovider - IPF	MEMORIAL HOSP & HCC (PSYCH)	15S115	99915	4	07/01/1985	N	P	O	4.00
5.00	Subprovider - IRF	MEMORIAL HOSP & HCC (REHAB)	15T115	99915	5	07/01/2005	N	P	O	5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF	MEMORIAL HOSP & HEALTH CARE CTR	155305	99915		08/04/1987	N	P	O	9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA	MEMORIAL HOSP & HEALTH CARE CTR	157222	99915		08/28/1991	N	P	N	12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC	FRENCH LICK FAMILY MEDICINE	158507	99915		06/19/2009	N	O	N	15.00
15.01	Hospital-Based Health Clinic - RHC II	LOOGOOTEE FAMILY MEDICINE	158508	99915		12/14/2009	N	O	N	15.01
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)	07/01/2021	06/30/2022	20.00
21.00	Type of Control (see instructions)	1		21.00

		1.00	2.00	3.00	
	Inpatient PPS Information				
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	Y	N		22.00
22.01	Did this hospital receive interim 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)	Y	Y		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: 15-0115 | Period: From 07/01/2021 To 06/30/2022 | Worksheet S-2 Part I Date/Time Prepared: 11/29/2022 11:30 am

		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.	3	N		23.00

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	287	240	0	0	1,781	176	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	32		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)	Y	Y	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	Y	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.	Y	Y		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.	Y	Y		57.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0115 | Period: From 07/01/2021 To 06/30/2022 | Worksheet S-2 Part I | Date/Time Prepared: 11/29/2022 11:30 am

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0115 | Period: From 07/01/2021 To 06/30/2022 | Worksheet S-2 Part I Date/Time Prepared: 11/29/2022 11:30 am

				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
				1.00	2.00	3.00	
	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.						
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	64.00

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00

				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
				1.00	2.00	3.00	
	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010						
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.50	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)	FAMILY MEDICINE	1350	2.38	6.85	0.257855	67.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0115 | Period: From 07/01/2021 To 06/30/2022 | Worksheet S-2 Part I | Date/Time Prepared: 11/29/2022 11:30 am

		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.	Y			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)	N	Y	1	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.	Y			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)	N	N	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?	N		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			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)			107.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0115 | Period: From 07/01/2021 To 06/30/2022 | Worksheet S-2 Part I Date/Time Prepared: 11/29/2022 11:30 am

				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.					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.	Y				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:	1,235,758	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0115 | Period: From 07/01/2021 To 06/30/2022 | Worksheet S-2 Part I | Date/Time Prepared: 11/29/2022 11:30 am

		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)	Y		140.00

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name: MEMORIAL HOSPITAL AND HEALTH CENTER	Contractor's Name: WPS	Contractor's Number: 08101	141.00
142.00	Street: 800 W 9TH STREET	PO Box:		142.00
143.00	City: JASPER	State: IN	Zip Code: 47546	143.00

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

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

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

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

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

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

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)		168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)		168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	9.99	169.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0115	Period: From 07/01/2021 To 06/30/2022	Worksheet S-2 Part I Date/Time Prepared: 11/29/2022 11:30 am

		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: 15-0115 | Period: From 07/01/2021 To 06/30/2022 | Worksheet S-2 Part II | Date/Time Prepared: 11/29/2022 11:30 am

		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	09/30/2022	Y	09/30/2022	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: 15-0115 | Period: From 07/01/2021 To 06/30/2022 | Worksheet S-2 Part II | Date/Time Prepared: 11/29/2022 11:30 am

		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions					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.					23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions					24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.					25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.					26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.					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.					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					29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.					30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.					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.					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.					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.					35.00
				Y/N	Date	
				1.00	2.00	
	Home Office Costs					
36.00	Were home office costs claimed on the cost report?					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.	KERRY		BEJARANO		41.00
42.00	Enter the employer/company name of the cost report preparer.	BKD, LLP				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	(317) 383-4000		KBEJARANO@BKD.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-0115	Period: From 07/01/2021 To 06/30/2022	Worksheet S-2 Part II Date/Time Prepared: 11/29/2022 11:30 am

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-0115 | Period: From 07/01/2021 To 06/30/2022 | Worksheet S-3 Part I | Date/Time Prepared: 11/29/2022 11:30 am

	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	70	25,550	0.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		70	25,550	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	26	9,490	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)		96	35,040	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF	40.00	10	3,650		0	16.00
17.00	SUBPROVIDER - IRF	41.00	8	2,920		0	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	44.00	14	5,110		0	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
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		128				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: 15-0115 | Period: From 07/01/2021 To 06/30/2022 | Worksheet S-3 Part I | Date/Time Prepared: 11/29/2022 11:30 am

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
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)	3,556	103	8,871			1.00
2.00	HMO and other (see instructions)	1,878	2,021				2.00
3.00	HMO IPF Subprovider	8	0				3.00
4.00	HMO IRF Subprovider	0	32				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	3,556	103	8,871			7.00
8.00	INTENSIVE CARE UNIT	1,641	129	4,472			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		55	1,600			13.00
14.00	Total (see instructions)	5,197	287	14,943	14.53	946.57	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	290	531	1,337	0.19	14.13	16.00
17.00	SUBPROVIDER - IRF	559	0	958	0.00	7.52	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	3,138	38	4,350	0.00	19.93	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	10,304	0	17,408	0.00	30.89	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	1,171	0	3,532	0.00	4.74	26.00
26.01	RURAL HEALTH CLINIC II	1,657	0	5,152	0.00	6.78	26.01
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				14.72	1,030.56	27.00
28.00	Observation Bed Days		560	3,442			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	176	423			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: 15-0115 | Period: From 07/01/2021 To 06/30/2022 | Worksheet S-3 Part I | Date/Time Prepared: 11/29/2022 11:30 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
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	1,641	245	3,238	1.00
2.00	HMO and other (see instructions)			0	0		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	1,641	245	3,238	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF	0.00	0	36	309	656	16.00
17.00	SUBPROVIDER - IRF	0.00	0	44	0	83	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	0.00					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
26.25	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 WAGE INDEX INFORMATION | Provider CCN: 15-0115 | Period: From 07/01/2021 To 06/30/2022 | Worksheet S-3 Part II | Date/Time Prepared: 11/29/2022 11:30 am

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	99,882,027	-1,417,009	98,465,018	2,101,563.00	46.85	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		3,497,621	0	3,497,621	31,428.65	111.29	3.00
4.00	Physician-Part A - Administrative		166,721	0	166,721	542.00	307.60	4.00
4.01	Physicians - Part A - Teaching		1,162,735	0	1,162,735	8,023.35	144.92	4.01
5.00	Physician and Non Physician-Part B		10,414,977	0	10,414,977	33,341.41	312.37	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		607,028	0	607,028	15,825.63	38.36	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		1,151,155	0	1,151,155	19,822.00	58.07	7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	1,399,390	-26,913	1,372,477	39,881.00	34.41	9.00
10.00	Excluded area salaries (see instructions)		38,396,551	-302,324	38,094,227	736,079.00	51.75	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		1,830,244	0	1,830,244	59,147.42	30.94	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		109,172	0	109,172	937.50	116.45	13.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00	14.00
14.01	Home office salaries		19,635,170	0	19,635,170	476,247.46	41.23	14.01
14.02	Related organization salaries		0	0	0	0.00	0.00	14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00	16.01
16.02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.02
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		13,517,792	0	13,517,792			17.00
18.00	Wage-related costs (other) (see instructions)							18.00
19.00	Excluded areas		7,798,555	0	7,798,555			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		333,938	0	333,938			21.00
22.00	Physician Part A - Administrative		6,679	0	6,679			22.00
22.01	Physician Part A - Teaching		84,598	0	84,598			22.01
23.00	Physician Part B		353,974	0	353,974			23.00
24.00	Wage-related costs (RHC/FQHC)		166,969	0	166,969			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
25.50	Home office wage-related (core)		3,399,706	0	3,399,706			25.50
25.51	Related organization wage-related (core)		0	0	0			25.51
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0			25.52

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0115 | Period: From 07/01/2021 To 06/30/2022 | Worksheet S-3 Part II | Date/Time Prepared: 11/29/2022 11:30 am

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.53	Home office: Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	0	0	0	0.00	0.00	26.00
27.00	Administrative & General	5.00	1,618,572	-190,843	1,427,729	82,846.00	17.23	27.00
28.00	Administrative & General under contract (see inst.)		4,013,646	0	4,013,646	42,203.52	95.10	28.00
29.00	Maintenance & Repairs	6.00	540,423	-2,539	537,884	5,666.00	94.93	29.00
30.00	Operation of Plant	7.00	0	0	0	0.00	0.00	30.00
31.00	Laundry & Linen Service	8.00	284,592	-596	283,996	16,845.00	16.86	31.00
32.00	Housekeeping	9.00	0	0	0	0.00	0.00	32.00
33.00	Housekeeping under contract (see instructions)		1,615,855	0	1,615,855	74,725.58	21.62	33.00
34.00	Dietary	10.00	1,077,975	-842,066	235,909	11,610.00	20.32	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	814,734	814,734	41,090.00	19.83	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	946,305	-25,851	920,454	21,934.00	41.96	38.00
39.00	Central Services and Supply	14.00	287,428	-4,258	283,170	13,229.00	21.41	39.00
40.00	Pharmacy	15.00	2,019,454	-1,694,969	324,485	6,387.00	50.80	40.00
41.00	Medical Records & Medical Records Library	16.00	0	0	0	0.00	0.00	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0115 | Period: From 07/01/2021 To 06/30/2022 | Worksheet S-3 Part III Date/Time Prepared: 11/29/2022 11:30 am

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		88,678,012	-1,417,009	87,261,003	2,110,051.06	41.35	1.00
2.00	Excluded area salaries (see instructions)		39,795,941	-329,237	39,466,704	775,960.00	50.86	2.00
3.00	Subtotal salaries (line 1 minus line 2)		48,882,071	-1,087,772	47,794,299	1,334,091.06	35.83	3.00
4.00	Subtotal other wages & related costs (see inst.)		21,574,586	0	21,574,586	536,332.38	40.23	4.00
5.00	Subtotal wage-related costs (see inst.)		16,924,177	0	16,924,177	0.00	35.41	5.00
6.00	Total (sum of lines 3 thru 5)		87,380,834	-1,087,772	86,293,062	1,870,423.44	46.14	6.00
7.00	Total overhead cost (see instructions)		12,404,250	-1,946,388	10,457,862	316,536.10	33.04	7.00

HOSPITAL WAGE RELATED COSTS	Provider CCN: 15-0115	Period: From 07/01/2021 To 06/30/2022	Worksheet S-3 Part IV Date/Time Prepared: 11/29/2022 11:30 am

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	1,515,428	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	12,141,362	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	79,257	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	1,781,838	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	485,694	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
	TAXES		
17.00	FICA-Employers Portion Only	6,121,989	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	5,344	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	131,592	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	22,262,504	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 15-0115 | Period: From 07/01/2021 To 06/30/2022 | Worksheet S-3 Part V | Date/Time Prepared: 11/29/2022 11:30 am

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

HOME HEALTH AGENCY STATISTICAL DATA | Provider CCN: 15-0115 | Component CCN: 15-7222 | Period: From 07/01/2021 To 06/30/2022 | Worksheet S-4 | Date/Time Prepared: 11/29/2022 11:30 am

Home Health Agency I | PPS

						1.00	
0.00	County				DUBOIS		0.00
		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
	HOME HEALTH AGENCY STATISTICAL DATA						
1.00	Home Health Aide Hours	0	2,321	122	1,702	4,145	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	859.00	45.00	630.00	1,534.00	2.00
				Number of Employees (Full Time Equivalent)			
		Enter the number of hours in your normal work week		Staff	Contract	Total	
		0		1.00	2.00	3.00	
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES						
3.00	Administrator and Assistant Administrator(s)		40.00	0.00	0.00	0.00	3.00
4.00	Director(s) and Assistant Director(s)			1.00	0.00	1.00	4.00
5.00	Other Administrative Personnel			4.81	0.00	4.81	5.00
6.00	Direct Nursing Service			12.89	0.00	12.89	6.00
7.00	Nursing Supervisor			0.78	0.00	0.78	7.00
8.00	Physical Therapy Service			5.89	0.00	5.89	8.00
9.00	Physical Therapy Supervisor			0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service			3.19	0.00	3.19	10.00
11.00	Occupational Therapy Supervisor			0.00	0.00	0.00	11.00
12.00	Speech Pathology Service			0.17	0.00	0.17	12.00
13.00	Speech Pathology Supervisor			0.00	0.00	0.00	13.00
14.00	Medical Social Service			0.17	0.00	0.17	14.00
15.00	Medical Social Service Supervisor			0.00	0.00	0.00	15.00
16.00	Home Health Aide			1.99	0.00	1.99	16.00
17.00	Home Health Aide Supervisor			0.00	0.00	0.00	17.00
18.00	Other (specify)			0.00	0.00	0.00	18.00
						CBSA Data	
						1.00	
	HOME HEALTH AGENCY CBSA CODES						
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.					1	19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).					99915	20.00
		Full Episodes					
		Without Outliers	With Outliers	LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		1.00	2.00	3.00	4.00	5.00	
	PPS ACTIVITY DATA						
21.00	Skilled Nursing Visits	3,298	863	91	31	4,283	21.00
22.00	Skilled Nursing Visit Charges	836,854	229,212	25,660	8,044	1,099,770	22.00
23.00	Physical Therapy Visits	2,017	950	28	32	3,027	23.00
24.00	Physical Therapy Visit Charges	545,048	256,243	7,730	8,806	817,827	24.00
25.00	Occupational Therapy Visits	755	746	6	22	1,529	25.00
26.00	Occupational Therapy Visit Charges	203,689	200,773	1,614	5,918	411,994	26.00
27.00	Speech Pathology Visits	35	29	0	1	65	27.00
28.00	Speech Pathology Visit Charges	9,415	7,801	0	269	17,485	28.00
29.00	Medical Social Service Visits	20	13	0	0	33	29.00
30.00	Medical Social Service Visit Charges	6,120	3,978	0	0	10,098	30.00
31.00	Home Health Aide Visits	882	461	1	23	1,367	31.00
32.00	Home Health Aide Visit Charges	103,194	53,937	117	2,691	159,939	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	7,007	3,062	126	109	10,304	33.00
34.00	Other Charges	0	0	0	0	0	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	1,704,320	751,944	35,121	25,728	2,517,113	35.00
36.00	Total Number of Episodes (standard/non outlier)	7,007		76	60	7,143	36.00
37.00	Total Number of Outlier Episodes		1,476		0	1,476	37.00
38.00	Total Non-Routine Medical Supply Charges	32,850	18,101	1,196	52	52,199	38.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-0115 | Component CCN: 15-8507 | Period: From 07/01/2021 To 06/30/2022 | Worksheet S-8 | Date/Time Prepared: 11/29/2022 11:30 am

RHC I | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			522 SOUTH MAPLE STREET		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	FRENCH LICK		IN	47432	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

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

				1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?			N		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		ORANGE				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	16:00	08:00	12:00	07:00	16:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 15-0115
Component CCN: 15-8507

Period:
From 07/01/2021
To 06/30/2022

Worksheet S-8

Date/Time Prepared:
11/29/2022 11:30 am

RHC I

Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	06:00	15:00				11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-0115 | Component CCN: 15-8508 | Period: From 07/01/2021 To 06/30/2022 | Worksheet S-8 | Date/Time Prepared: 11/29/2022 11:30 am

RHC II | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			105 COOPER STREET		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	LOOGOOTEE		IN	47553	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?			N		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		MARTIN				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: 15-0115
Component CCN: 15-8508

Period:
From 07/01/2021
To 06/30/2022

Worksheet S-8

Date/Time Prepared:
11/29/2022 11:30 am

RHC II | Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	07:00	13:00				11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-0115 | Period: From 07/01/2021 To 06/30/2022 | Worksheet S-10 | Date/Time Prepared: 11/29/2022 11:30 am

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.227694	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	20,775,013	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	N	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	67,465,959	6.00
7.00	Medicaid cost (line 1 times line 6)	15,361,594	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)	0	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)	0	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)	2,505,637	316,605	2,822,242	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	570,519	316,605	887,124	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)	570,519	316,605	887,124	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)	8,050,005	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	102,099	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	157,074	27.01
28.00	Non-Medicare bad debt expense (see instructions)	7,892,931	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	1,852,148	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	2,739,272	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	2,739,272	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0115 | Period: From 07/01/2021 To 06/30/2022 | Worksheet A | Date/Time Prepared: 11/29/2022 11:30 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		6,822,083	6,822,083	0	6,822,083	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		5,704,128	5,704,128	0	5,704,128	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,618,572	444,557	2,063,129	-154,097	1,909,032	5.00
6.00	00600	MAINTENANCE & REPAIRS	540,423	3,593,985	4,134,408	0	4,134,408	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	284,592	70,221	354,813	0	354,813	8.00
9.00	00900	HOUSEKEEPING	0	0	0	0	0	9.00
10.00	01000	DIETARY	1,077,975	619,100	1,697,075	-1,290,765	406,310	10.00
11.00	01100	CAFETERIA	0	0	0	1,282,650	1,282,650	11.00
13.00	01300	NURSING ADMINISTRATION	946,305	97,395	1,043,700	-74	1,043,626	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	287,428	167,628	455,056	-12,743	442,313	14.00
15.00	01500	PHARMACY	2,019,454	17,121,463	19,140,917	-18,537,387	603,530	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	1,151,155	1,151,155	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	1,321,234	1,238,388	2,559,622	-1,151,155	1,408,467	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,630,594	1,576,749	9,207,343	-2,155,316	7,052,027	30.00
31.00	03100	INTENSIVE CARE UNIT	3,398,220	222,466	3,620,686	-115,628	3,505,058	31.00
40.00	04000	SUBPROVIDER - IPF	1,284,770	33,906	1,318,676	-1,608	1,317,068	40.00
41.00	04100	SUBPROVIDER - IRF	557,775	143,207	700,982	-3,995	696,987	41.00
43.00	04300	NURSERY	0	0	0	653,417	653,417	43.00
44.00	04400	SKILLED NURSING FACILITY	1,399,390	184,781	1,584,171	-25,333	1,558,838	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,238,397	9,509,775	14,748,172	-72,353	14,675,819	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	1,306,835	1,306,835	52.00
53.00	05300	ANESTHESIOLOGY	3,686,317	650,995	4,337,312	-63,684	4,273,628	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,523,607	1,586,904	8,110,511	-237,638	7,872,873	54.00
56.00	05600	RADIOISOTOPE	181,502	642,115	823,617	-826	822,791	56.00
60.00	06000	LABORATORY	3,224,528	5,673,613	8,898,141	-118	8,898,023	60.00
65.00	06500	RESPIRATORY THERAPY	1,363,464	493,650	1,857,114	-6,801	1,850,313	65.00
66.00	06600	PHYSICAL THERAPY	2,901,353	265,996	3,167,349	-113,355	3,053,994	66.00
69.00	06900	ELECTROCARDIOLOGY	2,646,966	2,215,334	4,862,300	-71,518	4,790,782	69.00
69.01	06901	PULMONARY	0	0	0	0	0	69.01
69.02	06902	CARDIOPULMONARY	100,996	51,672	152,668	0	152,668	69.02
69.03	06903	SLEEP LAB	256,833	28,651	285,484	0	285,484	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	1,290,275	1,290,275	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	5,510,960	5,510,960	0	5,510,960	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	18,865,318	18,865,318	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	383,737	110,351	494,088	0	494,088	88.00
88.01	08801	RURAL HEALTH CLINIC II	503,774	49,931	553,705	0	553,705	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	510,154	580,910	1,091,064	-170,729	920,335	90.00
90.01	09001	IMED	0	0	0	0	0	90.01
90.02	09002	ONCOLOGY	2,482,651	974,541	3,457,192	-82,566	3,374,626	90.02
90.03	09003	OUTPATIENT CENTER	0	0	0	0	0	90.03
90.04	09004	HBURG URGENT CARE CLINIC	1,248,333	254,885	1,503,218	-100,860	1,402,358	90.04
90.05	09005	DIABETES MGMT CLINIC	60,564	2,156	62,720	0	62,720	90.05
91.00	09100	EMERGENCY	9,648,113	626,570	10,274,683	-228,529	10,046,154	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	2,467,266	163,234	2,630,500	-20,770	2,609,730	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
101.00	10100	HOME HEALTH AGENCY	2,024,818	354,803	2,379,621	-84,713	2,294,908	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)	67,820,105	67,787,103	135,607,208	-152,911	135,454,297	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	30,146,756	4,584,993	34,731,749	0	34,731,749	192.00
192.01	19201	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	866,493	19,941	886,434	0	886,434	192.01
194.00	07950	LODGE	2,744	11,457	14,201	0	14,201	194.00
194.01	07951	OTHER NRCC	0	0	0	0	0	194.01
194.02	07952	MEMORIAL HOSPITAL FOUNDATION	121,556	4,412	125,968	0	125,968	194.02
194.03	07953	MKT/PHY SERVICES	232,157	58,156	290,313	0	290,313	194.03
194.04	07954	COMMUNITY EDUCATION	383,689	114,338	498,027	0	498,027	194.04
194.05	07955	VOLUNTEER	262,056	17,098	279,154	0	279,154	194.05
194.06	07956	MAB	0	0	0	0	0	194.06
194.07	07957	OFFSITE COVID SCREENING	0	-56	-56	152,911	152,855	194.07

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0115 | Period: From 07/01/2021 To 06/30/2022 | Worksheet A | Date/Time Prepared: 11/29/2022 11:30 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
194.08	07958	PUBLIC RELATIONS	0	0	0	0	0	194.08
194.09	07959	UNUSED SPACE	0	0	0	0	0	194.09
194.10	07960	EMERGENCY PREPAREDNESS	46,471	1,396,414	1,442,885	0	1,442,885	194.10
194.11	07961	HOME OFFICE	0	0	0	0	0	194.11
200.00		TOTAL (SUM OF LINES 118 through 199)	99,882,027	73,993,856	173,875,883	0	173,875,883	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0115 | Period: From 07/01/2021 To 06/30/2022 | Worksheet A | Date/Time Prepared: 11/29/2022 11:30 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	915,054	7,737,137		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2,759	5,706,887		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	25,261,293	25,261,293		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	27,797,795	29,706,827		5.00
6.00	00600	MAINTENANCE & REPAIRS	1,899,410	6,033,818		6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	354,813		8.00
9.00	00900	HOUSEKEEPING	1,632,661	1,632,661		9.00
10.00	01000	DIETARY	-1,886	404,424		10.00
11.00	01100	CAFETERIA	-594,634	688,016		11.00
13.00	01300	NURSING ADMINISTRATION	-47,218	996,408		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-2,603	439,710		14.00
15.00	01500	PHARMACY	-298,853	304,677		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,600,731	1,600,731		16.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	1,151,155		21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	-263,171	1,145,296		22.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	7,052,027		30.00
31.00	03100	INTENSIVE CARE UNIT	0	3,505,058		31.00
40.00	04000	SUBPROVIDER - IPF	-178,361	1,138,707		40.00
41.00	04100	SUBPROVIDER - IRF	-87,665	609,322		41.00
43.00	04300	NURSERY	0	653,417		43.00
44.00	04400	SKILLED NURSING FACILITY	0	1,558,838		44.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-1,667,234	13,008,585		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,306,835		52.00
53.00	05300	ANESTHESIOLOGY	-3,907,840	365,788		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-3,995,413	3,877,460		54.00
56.00	05600	RADIOISOTOPE	0	822,791		56.00
60.00	06000	LABORATORY	-169,794	8,728,229		60.00
65.00	06500	RESPIRATORY THERAPY	-7,257	1,843,056		65.00
66.00	06600	PHYSICAL THERAPY	-402,375	2,651,619		66.00
69.00	06900	ELECTROCARDIOLOGY	-504,670	4,286,112		69.00
69.01	06901	PULMONARY	0	0		69.01
69.02	06902	CARDIOPULMONARY	0	152,668		69.02
69.03	06903	SLEEP LAB	-40	285,444		69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,290,275		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	5,510,960		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	18,865,318		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	-1,003	493,085		88.00
88.01	08801	RURAL HEALTH CLINIC II	-225	553,480		88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
90.00	09000	CLINIC	-326,973	593,362		90.00
90.01	09001	IMED	0	0		90.01
90.02	09002	ONCOLOGY	0	3,374,626		90.02
90.03	09003	OUTPATIENT CENTER	0	0		90.03
90.04	09004	HBURG URGENT CARE CLINIC	-298,957	1,103,401		90.04
90.05	09005	DIABETES MGMT CLINIC	0	62,720		90.05
91.00	09100	EMERGENCY	-5,324,911	4,721,243		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	-422,236	2,187,494		95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0		96.00
101.00	10100	HOME HEALTH AGENCY	0	2,294,908		101.00
		SPECIAL PURPOSE COST CENTERS				
116.00	11600	HOSPICE	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	40,606,384	176,060,681		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	34,731,749		192.00
192.01	19201	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	886,434		192.01
194.00	07950	LODGE	0	14,201		194.00
194.01	07951	OTHER NRCC	0	0		194.01
194.02	07952	MEMORIAL HOSPITAL FOUNDATION	0	125,968		194.02
194.03	07953	MKT/PHY SERVICES	3,462,944	3,753,257		194.03
194.04	07954	COMMUNITY EDUCATION	0	498,027		194.04
194.05	07955	VOLUNTEER	0	279,154		194.05
194.06	07956	MAB	0	0		194.06
194.07	07957	OFFSITE COVID SCREENING	0	152,855		194.07
194.08	07958	PUBLIC RELATIONS	107	107		194.08

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0115 | Period: From 07/01/2021 To 06/30/2022 | Worksheet A | Date/Time Prepared: 11/29/2022 11:30 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
194.09	07959	UNUSED SPACE	0	0		194.09
194.10	07960	EMERGENCY PREPAREDNESS	0	1,442,885		194.10
194.11	07961	HOME OFFICE	0	0		194.11
200.00		TOTAL (SUM OF LINES 118 through 199)	44,069,435	217,945,318		200.00

RECLASSIFICATIONS | Provider CCN: 15-0115 | Period: From 07/01/2021 To 06/30/2022 | Worksheet A-6 | Date/Time Prepared: 11/29/2022 11:30 am

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - LABOR AND DELIVERY				
1.00	NURSERY	43.00	583,454	69,963	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	1,166,909	139,926	2.00
	0		1,750,363	209,889	
	B - CAFETERIA				
1.00	CAFETERIA	11.00	814,734	467,916	1.00
	0		814,734	467,916	
	C - BILLABLE SUPPLES				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	1,290,275	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
	0		0	1,290,275	
	D - DRUGS RECLASS				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	17,226,363	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
	0		0	17,226,363	
	E - INTERN AND RESIDENT RECLASS				
1.00	I&R SERVICES-SALARY & FRINGES APPRVD	21.00	0	1,151,155	1.00
	0		0	1,151,155	
	F - DISABILITY LEAVE RECLASS				
1.00	ADMINISTRATIVE & GENERAL	5.00	0	52,809	1.00
2.00	MAINTENANCE & REPAIRS	6.00	0	2,539	2.00
3.00	LAUNDRY & LINEN SERVICE	8.00	0	596	3.00
4.00	DIETARY	10.00	0	27,332	4.00
5.00	NURSING ADMINISTRATION	13.00	0	25,851	5.00
6.00	CENTRAL SERVICES & SUPPLY	14.00	0	4,258	6.00
7.00	PHARMACY	15.00	0	56,014	7.00
8.00	ADULTS & PEDIATRICS	30.00	0	147,620	8.00
9.00	INTENSIVE CARE UNIT	31.00	0	69,787	9.00
10.00	SUBPROVIDER - IPF	40.00	0	12,420	10.00
11.00	SUBPROVIDER - IRF	41.00	0	9,843	11.00
12.00	SKILLED NURSING FACILITY	44.00	0	26,913	12.00
13.00	OPERATING ROOM	50.00	0	68,393	13.00
14.00	ANESTHESIOLOGY	53.00	0	107,785	14.00
15.00	RADIOLOGY-DIAGNOSTIC	54.00	0	29,509	15.00

RECLASSIFICATIONS | Provider CCN: 15-0115 | Period: From 07/01/2021 To 06/30/2022 | Worksheet A-6 | Date/Time Prepared: 11/29/2022 11:30 am

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
16.00	LABORATORY	60.00	0	19,648		16.00
17.00	RESPIRATORY THERAPY	65.00	0	20,577		17.00
18.00	PHYSICAL THERAPY	66.00	0	103,642		18.00
19.00	ELECTROCARDIOLOGY	69.00	0	46,446		19.00
20.00	SLEEP LAB	69.03	0	3,441		20.00
21.00	RURAL HEALTH CLINIC	88.00	0	558		21.00
22.00	RURAL HEALTH CLINIC II	88.01	0	10,188		22.00
23.00	CLINIC	90.00	0	16,299		23.00
24.00	ONCOLOGY	90.02	0	48,844		24.00
25.00	HBURG URGENT CARE CLINIC	90.04	0	47,877		25.00
26.00	EMERGENCY	91.00	0	39,725		26.00
27.00	AMBULANCE SERVICES	95.00	0	63,044		27.00
28.00	HOME HEALTH AGENCY	101.00	0	38,001		28.00
29.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	297,829		29.00
30.00	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	192.01	0	8,529		30.00
31.00	COMMUNITY EDUCATION	194.04	0	2,353		31.00
32.00	VOLUNTEER	194.05	0	8,339		32.00
	0		0	1,417,009		
	G - PHARMACY RECLASS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	1,638,955	0		1.00
	TOTALS		1,638,955	0		
	H - VOLUNTEER/GUEST SVC					
1.00	OFFSITE COVID SCREENING	194.07	138,034	14,877		1.00
	TOTALS		138,034	14,877		
500.00	Grand Total: Increases		4,342,086	21,777,484		500.00

RECLASSIFICATIONS | Provider CCN: 15-0115 | Period: From 07/01/2021 To 06/30/2022 | Worksheet A-6 | Date/Time Prepared: 11/29/2022 11:30 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - LABOR AND DELIVERY						
1.00	ADULTS & PEDIATRICS	30.00	1,750,363	209,889	0		1.00
2.00		0.00	0	0	0		2.00
	0		1,750,363	209,889			
	B - CAFETERIA						
1.00	DIETARY	10.00	814,734	467,916	0		1.00
	0		814,734	467,916			
	C - BILLABLE SUPPLES						
1.00	NURSING ADMINISTRATION	13.00	0	74	0		1.00
2.00	CENTRAL SERVICES & SUPPLY	14.00	0	12,704	0		2.00
3.00	PHARMACY	15.00	0	2,310	0		3.00
4.00	ADULTS & PEDIATRICS	30.00	0	194,479	0		4.00
5.00	INTENSIVE CARE UNIT	31.00	0	115,566	0		5.00
6.00	SUBPROVIDER - IPF	40.00	0	1,588	0		6.00
7.00	SUBPROVIDER - IRF	41.00	0	3,995	0		7.00
8.00	SKILLED NURSING FACILITY	44.00	0	25,333	0		8.00
9.00	OPERATING ROOM	50.00	0	72,121	0		9.00
10.00	ANESTHESIOLOGY	53.00	0	3,479	0		10.00
11.00	RADIOLOGY-DIAGNOSTIC	54.00	0	89,093	0		11.00
12.00	RADIOISOTOPE	56.00	0	584	0		12.00
13.00	LABORATORY	60.00	0	118	0		13.00
14.00	RESPIRATORY THERAPY	65.00	0	5,952	0		14.00
15.00	PHYSICAL THERAPY	66.00	0	111,659	0		15.00
16.00	ELECTROCARDIOLOGY	69.00	0	47,114	0		16.00
17.00	CLINIC	90.00	0	158,863	0		17.00
18.00	ONCOLOGY	90.02	0	82,552	0		18.00
19.00	HBURG URGENT CARE CLINIC	90.04	0	85,243	0		19.00
20.00	EMERGENCY	91.00	0	213,736	0		20.00
21.00	AMBULANCE SERVICES	95.00	0	10,687	0		21.00
22.00	HOME HEALTH AGENCY	101.00	0	53,025	0		22.00
	0		0	1,290,275			
	D - DRUGS RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	1,186	0		1.00
2.00	DIETARY	10.00	0	8,115	0		2.00
3.00	CENTRAL SERVICES & SUPPLY	14.00	0	39	0		3.00
4.00	PHARMACY	15.00	0	16,896,122	0		4.00
5.00	ADULTS & PEDIATRICS	30.00	0	585	0		5.00
6.00	INTENSIVE CARE UNIT	31.00	0	62	0		6.00
7.00	SUBPROVIDER - IPF	40.00	0	20	0		7.00
8.00	OPERATING ROOM	50.00	0	232	0		8.00
9.00	ANESTHESIOLOGY	53.00	0	60,205	0		9.00
10.00	RADIOLOGY-DIAGNOSTIC	54.00	0	148,545	0		10.00
11.00	RADIOISOTOPE	56.00	0	242	0		11.00
12.00	RESPIRATORY THERAPY	65.00	0	849	0		12.00
13.00	PHYSICAL THERAPY	66.00	0	1,696	0		13.00
14.00	ELECTROCARDIOLOGY	69.00	0	24,404	0		14.00
15.00	CLINIC	90.00	0	11,866	0		15.00
16.00	ONCOLOGY	90.02	0	14	0		16.00
17.00	HBURG URGENT CARE CLINIC	90.04	0	15,617	0		17.00
18.00	EMERGENCY	91.00	0	14,793	0		18.00
19.00	AMBULANCE SERVICES	95.00	0	10,083	0		19.00
20.00	HOME HEALTH AGENCY	101.00	0	31,688	0		20.00
	0		0	17,226,363			
	E - INTERN AND RESIDENT RECLASS						
1.00	I&R SERVICES-OTHER PRGM. COSTS APPRVD	22.00	0	1,151,155	0		1.00
	0		0	1,151,155			
	F - DISABILITY LEAVE RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	52,809	0	0		1.00
2.00	MAINTENANCE & REPAIRS	6.00	2,539	0	0		2.00
3.00	LAUNDRY & LINEN SERVICE	8.00	596	0	0		3.00
4.00	DIETARY	10.00	27,332	0	0		4.00
5.00	NURSING ADMINISTRATION	13.00	25,851	0	0		5.00
6.00	CENTRAL SERVICES & SUPPLY	14.00	4,258	0	0		6.00
7.00	PHARMACY	15.00	56,014	0	0		7.00
8.00	ADULTS & PEDIATRICS	30.00	147,620	0	0		8.00
9.00	INTENSIVE CARE UNIT	31.00	69,787	0	0		9.00
10.00	SUBPROVIDER - IPF	40.00	12,420	0	0		10.00
11.00	SUBPROVIDER - IRF	41.00	9,843	0	0		11.00
12.00	SKILLED NURSING FACILITY	44.00	26,913	0	0		12.00
13.00	OPERATING ROOM	50.00	68,393	0	0		13.00
14.00	ANESTHESIOLOGY	53.00	107,785	0	0		14.00
15.00	RADIOLOGY-DIAGNOSTIC	54.00	29,509	0	0		15.00
16.00	LABORATORY	60.00	19,648	0	0		16.00

RECLASSIFICATIONS | Provider CCN: 15-0115 | Period: From 07/01/2021 To 06/30/2022 | Worksheet A-6 | Date/Time Prepared: 11/29/2022 11:30 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
17.00	RESPIRATORY THERAPY	65.00	20,577	0	0		17.00
18.00	PHYSICAL THERAPY	66.00	103,642	0	0		18.00
19.00	ELECTROCARDIOLOGY	69.00	46,446	0	0		19.00
20.00	SLEEP LAB	69.03	3,441	0	0		20.00
21.00	RURAL HEALTH CLINIC	88.00	558	0	0		21.00
22.00	RURAL HEALTH CLINIC II	88.01	10,188	0	0		22.00
23.00	CLINIC	90.00	16,299	0	0		23.00
24.00	ONCOLOGY	90.02	48,844	0	0		24.00
25.00	HBURG URGENT CARE CLINIC	90.04	47,877	0	0		25.00
26.00	EMERGENCY	91.00	39,725	0	0		26.00
27.00	AMBULANCE SERVICES	95.00	63,044	0	0		27.00
28.00	HOME HEALTH AGENCY	101.00	38,001	0	0		28.00
29.00	PHYSICIANS' PRIVATE OFFICES	192.00	297,829	0	0		29.00
30.00	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	192.01	8,529	0	0		30.00
31.00	COMMUNITY EDUCATION	194.04	2,353	0	0		31.00
32.00	VOLUNTEER	194.05	8,339	0	0		32.00
	0		1,417,009	0			
	G - PHARMACY RECLASS						
1.00	PHARMACY	15.00	1,638,955	0	0		1.00
	TOTALS		1,638,955	0			
	H - VOLUNTEER/GUEST SVC						
1.00	ADMINISTRATIVE & GENERAL	5.00	138,034	14,877	0		1.00
	TOTALS		138,034	14,877			
500.00	Grand Total: Decreases		5,759,095	20,360,475			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0115 | Period: From 07/01/2021 To 06/30/2022 | Worksheet A-7 Part I | Date/Time Prepared: 11/29/2022 11:30 am

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	11,154,563	33,525	0	33,525	0	1.00
2.00	Land Improvements	0	0	0	0	0	2.00
3.00	Buildings and Fixtures	121,605,691	893,243	0	893,243	0	3.00
4.00	Building Improvements	30,809,760	0	0	0	30,809,760	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	114,778,710	44,132,850	0	44,132,850	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	278,348,724	45,059,618	0	45,059,618	30,809,760	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	278,348,724	45,059,618	0	45,059,618	30,809,760	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	11,188,088	0	1.00
2.00	Land Improvements	0	0	2.00
3.00	Buildings and Fixtures	122,498,934	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	158,911,560	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	292,598,582	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	292,598,582	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0115 | Period: From 07/01/2021 To 06/30/2022 | Worksheet A-7 Part II | Date/Time Prepared: 11/29/2022 11:30 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	3,476,189	841,323	2,344,574	159,997	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	5,704,128	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	9,180,317	841,323	2,344,574	159,997	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL			
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)		
		14.00	15.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2				
1.00	CAP REL COSTS-BLDG & FIXT	0	6,822,083		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	5,704,128		2.00
3.00	Total (sum of lines 1-2)	0	12,526,211		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0115 | Period: From 07/01/2021 To 06/30/2022 | Worksheet A-7 Part III | Date/Time Prepared: 11/29/2022 11:30 am

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	133,687,022	0	133,687,022	0.456896	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	158,911,560	0	158,911,560	0.543104	0	2.00
3.00	Total (sum of lines 1-2)	292,598,582	0	292,598,582	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	6,735,817	841,323	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	5,706,887	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	12,442,704	841,323	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	159,997	0	0	7,737,137	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	5,706,887	2.00
3.00	Total (sum of lines 1-2)	0	159,997	0	0	13,444,024	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0115 | Period: From 07/01/2021 To 06/30/2022 | Worksheet A-8 | Date/Time Prepared: 11/29/2022 11:30 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-2,344,574	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		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	-12,640,269			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)	B	-5,945	ADMINISTRATIVE & GENERAL	5.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	64,804,263			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-594,634	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients	B	-298,853	PHARMACY	15.00	0	17.00
18.00	Sale of medical records and abstracts	B	-26,479	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0115 | Period: From 07/01/2021 To 06/30/2022 | Worksheet A-8 | Date/Time Prepared: 11/29/2022 11:30 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	ADVERTISING - NURSING ADMIN	A	-2,155	NURSING ADMINISTRATION	13.00	0	33.00
33.01	ADVERTISING - SKILLED NURSING	A	0	ADULTS & PEDIATRICS	30.00	0	33.01
33.02	ADVERTISING - CARING HANDS	A	-240	SUBPROVIDER - IPF	40.00	0	33.02
33.03	ADVERTISING - PT	A	0	PHYSICAL THERAPY	66.00	0	33.03
33.04	ADVERTISING - SLEEP CENTER	A	0	SLEEP LAB	69.03	0	33.04
33.05	ADVERTISING - FRENCH LICK	A	-1,003	RURAL HEALTH CLINIC	88.00	0	33.05
33.06	ADVERTISING - LOOGOOTEE	A	-225	RURAL HEALTH CLINIC II	88.01	0	33.06
33.07	ADVERTISING - WOUND CARE	A	0	CLINIC	90.00	0	33.07
33.08	ADVERTISING - HUNTINGBURG	A	-140	HBURG URGENT CARE CLINIC	90.04	0	33.08
33.09	ADVERTISING - AMBULANCE	A	-4,709	AMBULANCE SERVICES	95.00	0	33.09
33.10	PHYSICIAN RECRUITMENT	A	-960	I&R SERVICES-OTHER PRGM. COSTS APPRVD	22.00	0	33.10
33.11	MISCELLANEOUS REVENUE - ADMIN	B	-606,196	ADMINISTRATIVE & GENERAL	5.00	0	33.11
33.12	MISCELLANEOUS - ENGINEERING	B	0	MAINTENANCE & REPAIRS	6.00	0	33.12
33.13	MISCELLANEOUS - DIETARY	B	-1,886	DIETARY	10.00	0	33.13
33.15	MISCELLANEOUS - CLINICAL	B	-45,063	NURSING ADMINISTRATION	13.00	0	33.15
33.16	MISCELLANEOUS - STERILE PROC	B	-2,603	CENTRAL SERVICES & SUPPLY	14.00	0	33.16
33.17	MISCELLANEOUS - PERINATAL SVCS	B	0	ADULTS & PEDIATRICS	30.00	0	33.17
33.18	MISCELLANEOUS - REHAB	B	-58,645	SUBPROVIDER - IRF	41.00	0	33.18
33.19	MISCELLANEOUS - RADIOLOGY	B	-257	RADIOLOGY-DIAGNOSTIC	54.00	0	33.19
33.20	MISCELLANEOUS - LABS	B	-19,794	LABORATORY	60.00	0	33.20
33.21	MISCELLANEOUS - THERAPY	B	-399,442	PHYSICAL THERAPY	66.00	0	33.21
33.22	MISCELLANEOUS - SLEEP LAB	B	-40	SLEEP LAB	69.03	0	33.22
33.23	MISCELLANEOUS - FRENCH LICK	B	0	RURAL HEALTH CLINIC	88.00	0	33.23
33.25	MISCELLANEOUS - HBURG URGENT CARE CL	B	0	HBURG URGENT CARE CLINIC	90.04	0	33.25
33.26	MISCELLANEOUS - AMBULANCE	B	-417,108	AMBULANCE SERVICES	95.00	0	33.26
33.27	CRNA EXPENSE	A	-913,013	OPERATING ROOM	50.00	0	33.27
33.28	CRNA EXPENSE	A	-2,584,608	ANESTHESIOLOGY	53.00	0	33.28
33.29	I/R START UP COSTS AMORTIZATION	A	2,759	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.29
33.30	I/R START UP COSTS AMORTIZATION	A	11,370	MAINTENANCE & REPAIRS	6.00	0	33.30
33.31	I/R START UP COSTS AMORTIZATION	A	219,884	I&R SERVICES-OTHER PRGM. COSTS APPRVD	22.00	0	33.31
33.32	GAINSHARE	A	0	ADMINISTRATIVE & GENERAL	5.00	0	33.32
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		44,069,435				50.00

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 15-0115 | Period: From 07/01/2021 To 06/30/2022 | Worksheet A-8-1 | Date/Time Prepared: 11/29/2022 11:30 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	50.00	OPERATING ROOM	AMBULATORY SURGERY CENTER	3,353,161	4,090,717	1.00
2.00	1.00	CAP REL COSTS-BLDG & FIXT	NEW CAPITAL	3,259,628	0	2.00
3.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	BENEFITS	25,261,293	0	3.00
4.00	5.00	ADMINISTRATIVE & GENERAL	A&G	28,409,936	0	4.00
4.01	6.00	MAINTENANCE & REPAIRS	PLANT ENGINEERING	1,888,040	0	4.01
4.02	9.00	HOUSEKEEPING	ENVIRONMENTAL SERVICES	1,632,661	0	4.02
4.03	16.00	MEDICAL RECORDS & LIBRARY	MEDICAL RECORDS	1,627,210	0	4.03
4.04	194.03	MKT/PHY SERVICES	PHYSICIAN SERVICES	3,462,944	0	4.04
4.05	194.08	PUBLIC RELATIONS	PUBLIC RELATIONS	107	0	4.05
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			68,894,980	4,090,717	5.00

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

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

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

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

6.00	C	MHHCC	0.00	MEM HOS OP SURG	40.00	6.00
7.00	B		0.00	MEMORIAL HOME O	100.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 15-0115	Period: From 07/01/2021 To 06/30/2022	Worksheet A-8-1 Date/Time Prepared: 11/29/2022 11:30 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	-737,556	0		1.00
2.00	3,259,628	9		2.00
3.00	25,261,293	0		3.00
4.00	28,409,936	0		4.00
4.01	1,888,040	0		4.01
4.02	1,632,661	0		4.02
4.03	1,627,210	0		4.03
4.04	3,462,944	0		4.04
4.05	107	0		4.05
5.00	64,804,263			5.00

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

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

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

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

6.00	SURGERY CENTER		6.00
7.00	HOME OFFICE		7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-0115 | Period: From 07/01/2021 To 06/30/2022 | Worksheet A-8-2 | Date/Time Prepared: 11/29/2022 11:30 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	22.00	I&R SERVICES-OTHER PRGM. COSTS APPRVD	1,243,894	0	1,243,894	197,500	8,023	1.00
2.00	40.00	SUBPROVIDER - IPF	178,121	178,121	0	181,300	0	2.00
3.00	41.00	SUBPROVIDER - IRF	29,020	29,020	0	179,000	0	3.00
4.00	50.00	OPERATING ROOM	16,665	16,665	0	246,400	0	4.00
5.00	53.00	ANESTHESIOLOGY	1,323,232	1,323,232	0	239,400	0	5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	3,995,156	3,995,156	0	271,900	0	6.00
7.00	60.00	LABORATORY	150,000	150,000	0	271,900	0	7.00
8.00	65.00	RESPIRATORY THERAPY	7,257	7,257	0	211,500	0	8.00
9.00	66.00	PHYSICAL THERAPY	2,933	2,933	0	211,500	0	9.00
10.00	69.00	ELECTROCARDIOLOGY	504,670	504,670	0	211,500	0	10.00
11.00	90.00	CLINIC	326,973	326,973	0	211,500	0	11.00
12.00	90.04	HBURG URGENT CARE CLINIC	298,817	298,817	0	211,500	0	12.00
13.00	91.00	EMERGENCY	5,324,911	5,324,911	0	211,500	0	13.00
14.00	95.00	AMBULANCE SERVICES	419	419	0	211,500	0	14.00
200.00			13,402,068	12,158,174	1,243,894		8,023	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	22.00	I&R SERVICES-OTHER PRGM. COSTS APPRVD	761,799	38,090	0	0	0	1.00
2.00	40.00	SUBPROVIDER - IPF	0	0	0	0	0	2.00
3.00	41.00	SUBPROVIDER - IRF	0	0	0	0	0	3.00
4.00	50.00	OPERATING ROOM	0	0	0	0	0	4.00
5.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	6.00
7.00	60.00	LABORATORY	0	0	0	0	0	7.00
8.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	8.00
9.00	66.00	PHYSICAL THERAPY	0	0	0	0	0	9.00
10.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	10.00
11.00	90.00	CLINIC	0	0	0	0	0	11.00
12.00	90.04	HBURG URGENT CARE CLINIC	0	0	0	0	0	12.00
13.00	91.00	EMERGENCY	0	0	0	0	0	13.00
14.00	95.00	AMBULANCE SERVICES	0	0	0	0	0	14.00
200.00			761,799	38,090	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	22.00	I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	761,799	482,095	482,095		1.00
2.00	40.00	SUBPROVIDER - IPF	0	0	0	178,121		2.00
3.00	41.00	SUBPROVIDER - IRF	0	0	0	29,020		3.00
4.00	50.00	OPERATING ROOM	0	0	0	16,665		4.00
5.00	53.00	ANESTHESIOLOGY	0	0	0	1,323,232		5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	3,995,156		6.00
7.00	60.00	LABORATORY	0	0	0	150,000		7.00
8.00	65.00	RESPIRATORY THERAPY	0	0	0	7,257		8.00
9.00	66.00	PHYSICAL THERAPY	0	0	0	2,933		9.00
10.00	69.00	ELECTROCARDIOLOGY	0	0	0	504,670		10.00
11.00	90.00	CLINIC	0	0	0	326,973		11.00
12.00	90.04	HBURG URGENT CARE CLINIC	0	0	0	298,817		12.00
13.00	91.00	EMERGENCY	0	0	0	5,324,911		13.00
14.00	95.00	AMBULANCE SERVICES	0	0	0	419		14.00
200.00			0	761,799	482,095	12,640,269		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0115 | Period: From 07/01/2021 To 06/30/2022 | Worksheet B Part I Date/Time Prepared: 11/29/2022 11:30 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	7,737,137	7,737,137				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	5,706,887		5,706,887			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	25,261,293	0	0	25,261,293		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	29,706,827	213,584	157,539	366,285	30,444,235	5.00
6.00	00600	MAINTENANCE & REPAIRS	6,033,818	4,525	3,337	137,995	6,179,675	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	354,813	24,517	18,084	72,859	470,273	8.00
9.00	00900	HOUSEKEEPING	1,632,661	0	0	0	1,632,661	9.00
10.00	01000	DIETARY	404,424	24,289	17,915	60,523	507,151	10.00
11.00	01100	CAFETERIA	688,016	75,158	55,437	209,021	1,027,632	11.00
13.00	01300	NURSING ADMINISTRATION	996,408	17,050	12,576	236,143	1,262,177	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	439,710	14,216	10,486	72,648	537,060	14.00
15.00	01500	PHARMACY	304,677	44,704	32,974	83,247	465,602	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,600,731	0	0	0	1,600,731	16.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	1,151,155	0	0	0	1,151,155	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	1,145,296	63,031	46,491	338,964	1,593,782	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,052,027	383,039	282,529	1,470,707	9,188,302	30.00
31.00	03100	INTENSIVE CARE UNIT	3,505,058	175,866	129,718	853,913	4,664,555	31.00
40.00	04000	SUBPROVIDER - IPF	1,138,707	138,933	102,477	326,423	1,706,540	40.00
41.00	04100	SUBPROVIDER - IRF	609,322	72,486	53,465	140,573	875,846	41.00
43.00	04300	NURSERY	653,417	45,482	33,548	149,686	882,133	43.00
44.00	04400	SKILLED NURSING FACILITY	1,558,838	78,829	58,144	352,110	2,047,921	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	13,008,585	522,218	385,186	1,326,370	15,242,359	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,306,835	90,965	67,095	299,372	1,764,267	52.00
53.00	05300	ANESTHESIOLOGY	365,788	0	0	918,076	1,283,864	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,877,460	175,620	129,537	1,666,067	5,848,684	54.00
56.00	05600	RADIOISOTOPE	822,791	11,933	8,802	46,565	890,091	56.00
60.00	06000	LABORATORY	8,728,229	84,757	62,517	822,215	9,697,718	60.00
65.00	06500	RESPIRATORY THERAPY	1,843,056	31,105	22,943	344,519	2,241,623	65.00
66.00	06600	PHYSICAL THERAPY	2,651,619	72,655	53,590	717,756	3,495,620	66.00
69.00	06900	ELECTROCARDIOLOGY	4,286,112	165,480	122,058	667,166	5,240,816	69.00
69.01	06901	PULMONARY	0	0	0	0	0	69.01
69.02	06902	CARDIOPULMONARY	152,668	20,568	15,171	25,911	214,318	69.02
69.03	06903	SLEEP LAB	285,444	23,629	17,429	65,008	391,510	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,290,275	0	0	0	1,290,275	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,510,960	0	0	0	5,510,960	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	18,865,318	0	0	420,476	19,285,794	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	493,085	24,297	17,922	98,305	633,609	88.00
88.01	08801	RURAL HEALTH CLINIC II	553,480	56,054	41,345	126,630	777,509	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	593,362	71,987	53,097	126,699	845,145	90.00
90.01	09001	IMED	0	0	0	0	0	90.01
90.02	09002	ONCOLOGY	3,374,626	152,761	112,676	624,396	4,264,459	90.02
90.03	09003	OUTPATIENT CENTER	0	0	0	0	0	90.03
90.04	09004	HBURG URGENT CARE CLINIC	1,103,401	67,522	49,804	307,978	1,528,705	90.04
90.05	09005	DIABETES MGMT CLINIC	62,720	6,969	5,140	15,538	90,367	90.05
91.00	09100	EMERGENCY	4,721,243	135,940	100,269	2,465,042	7,422,494	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	2,187,494	27,367	20,186	616,806	2,851,853	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
101.00	10100	HOME HEALTH AGENCY	2,294,908	31,782	23,442	509,720	2,859,852	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)	176,060,681	3,149,318	2,322,929	17,081,712	159,909,323	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	12,593	9,288	0	21,881	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	34,731,749	1,292,440	953,300	7,657,762	44,635,251	192.00
192.01	19201	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	886,434	31,139	22,968	220,112	1,160,653	192.01
194.00	07950	LODGE	14,201	365,305	269,448	704	649,658	194.00
194.01	07951	OTHER NRCC	0	0	0	0	0	194.01
194.02	07952	MEMORIAL HOSPITAL FOUNDATION	125,968	12,736	9,394	31,185	179,283	194.02
194.03	07953	MKT/PHY SERVICES	3,753,257	1,015	749	59,560	3,814,581	194.03
194.04	07954	COMMUNITY EDUCATION	498,027	62,490	46,092	97,832	704,441	194.04

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0115 | Period: From 07/01/2021 To 06/30/2022 | Worksheet B Part I Date/Time Prepared: 11/29/2022 11:30 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
194.05	07955	VOLUNTEER	279,154	0	0	65,091	344,245	194.05
194.06	07956	MAB	0	0	0	0	0	194.06
194.07	07957	OFFSITE COVID SCREENING	152,855	0	0	35,413	188,268	194.07
194.08	07958	PUBLIC RELATIONS	107	0	0	0	107	194.08
194.09	07959	UNUSED SPACE	0	0	0	0	0	194.09
194.10	07960	EMERGENCY PREPAREDNESS	1,442,885	0	0	11,922	1,454,807	194.10
194.11	07961	HOME OFFICE	0	2,810,101	2,072,719	0	4,882,820	194.11
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)	217,945,318	7,737,137	5,706,887	25,261,293	217,945,318	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0115 | Period: From 07/01/2021 To 06/30/2022 | Worksheet B Part I | Date/Time Prepared: 11/29/2022 11:30 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	6.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	30,444,235					5.00
6.00	00600	MAINTENANCE & REPAIRS	1,003,381	7,183,056				6.00
8.00	00800	LAUNDRY & LINEN SERVICE	76,357	23,422	570,052			8.00
9.00	00900	HOUSEKEEPING	265,092	0	0	1,897,753		9.00
10.00	01000	DIETARY	82,345	23,204	4,493	6,150	623,343	10.00
11.00	01100	CAFETERIA	166,855	71,800	0	19,032	0	11.00
13.00	01300	NURSING ADMINISTRATION	204,937	16,288	0	4,317	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	87,201	13,581	20,090	3,600	0	14.00
15.00	01500	PHARMACY	75,599	42,707	0	11,320	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	259,907	0	0	0	0	16.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	186,911	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	258,779	60,214	0	15,961	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,491,886	365,924	111,184	96,993	263,204	30.00
31.00	03100	INTENSIVE CARE UNIT	757,374	168,007	42,363	44,533	126,645	31.00
40.00	04000	SUBPROVIDER - IPF	277,087	132,725	8,408	35,181	37,863	40.00
41.00	04100	SUBPROVIDER - IRF	142,209	69,247	11,079	18,355	27,130	41.00
43.00	04300	NURSERY	143,230	43,450	306	11,517	45,311	43.00
44.00	04400	SKILLED NURSING FACILITY	332,517	75,306	24,549	19,961	123,190	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,474,871	498,884	89,662	132,236	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	286,461	86,900	30,301	23,034	0	52.00
53.00	05300	ANESTHESIOLOGY	208,458	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	949,639	167,773	69,584	44,470	0	54.00
56.00	05600	RADIOISOTOPE	144,522	11,400	0	3,022	0	56.00
60.00	06000	LABORATORY	1,574,599	80,970	2,114	21,462	0	60.00
65.00	06500	RESPIRATORY THERAPY	363,968	29,715	0	7,876	0	65.00
66.00	06600	PHYSICAL THERAPY	567,577	69,409	17,721	18,398	0	66.00
69.00	06900	ELECTROCARDIOLOGY	850,941	158,086	35,120	41,903	0	69.00
69.01	06901	PULMONARY	0	0	0	0	0	69.01
69.02	06902	CARDIOPULMONARY	34,798	19,649	533	5,208	0	69.02
69.03	06903	SLEEP LAB	63,569	22,573	3,288	5,983	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	209,499	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	894,804	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,131,396	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	102,878	23,212	0	6,153	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	126,243	53,549	0	14,194	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	137,225	68,770	1,006	18,228	0	90.00
90.01	09001	IMED	0	0	0	0	0	90.01
90.02	09002	ONCOLOGY	692,412	145,935	13,194	38,682	0	90.02
90.03	09003	OUTPATIENT CENTER	0	0	1,292	0	0	90.03
90.04	09004	HBURG URGENT CARE CLINIC	248,213	64,504	79,759	17,098	0	90.04
90.05	09005	DIABETES MGMT CLINIC	14,673	6,657	0	1,765	0	90.05
91.00	09100	EMERGENCY	1,205,176	129,865	0	34,422	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	463,050	26,144	43	6,930	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
101.00	10100	HOME HEALTH AGENCY	464,348	30,362	0	8,048	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)	21,020,987	2,800,232	566,089	736,032	623,343	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	3,553	12,030	0	3,189	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	7,247,395	1,234,690	3,963	327,271	0	192.00
192.01	19201	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	188,453	29,748	0	7,885	0	192.01
194.00	07950	LODGE	105,484	348,982	0	92,502	0	194.00
194.01	07951	OTHER NRCC	0	0	0	0	0	194.01
194.02	07952	MEMORIAL HOSPITAL FOUNDATION	29,110	12,167	0	3,225	0	194.02
194.03	07953	MKT/PHY SERVICES	619,366	970	0	257	0	194.03
194.04	07954	COMMUNITY EDUCATION	114,379	59,697	0	15,824	0	194.04
194.05	07955	VOLUNTEER	55,894	0	0	0	0	194.05
194.06	07956	MAB	0	0	0	0	0	194.06
194.07	07957	OFFSITE COVID SCREENING	30,569	0	0	0	0	194.07
194.08	07958	PUBLIC RELATIONS	17	0	0	0	0	194.08
194.09	07959	UNUSED SPACE	0	0	0	0	0	194.09

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0115 | Period: From 07/01/2021 To 06/30/2022 | Worksheet B Part I Date/Time Prepared: 11/29/2022 11:30 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	6.00	8.00	9.00	10.00	
194.10	07960	EMERGENCY PREPAREDNESS	236,214	0	0	0	0	194.10
194.11	07961	HOME OFFICE	792,814	2,684,540	0	711,568	0	194.11
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)	30,444,235	7,183,056	570,052	1,897,753	623,343	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0115 | Period: From 07/01/2021 To 06/30/2022 | Worksheet B Part I | Date/Time Prepared: 11/29/2022 11:30 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	1,285,319					11.00
13.00	01300	NURSING ADMINISTRATION	14,867	1,502,586				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	8,798	0	670,330			14.00
15.00	01500	PHARMACY	5,073	0	4,384	604,685		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	1,860,638	16.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	7,930	0	60	0	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	103,432	684,640	20,367	0	35,615	30.00
31.00	03100	INTENSIVE CARE UNIT	57,905	383,287	5,346	0	27,136	31.00
40.00	04000	SUBPROVIDER - IPF	18,966	125,543	644	0	6,120	40.00
41.00	04100	SUBPROVIDER - IRF	10,087	66,771	448	0	3,760	41.00
43.00	04300	NURSERY	9,866	65,306	0	0	4,404	43.00
44.00	04400	SKILLED NURSING FACILITY	26,746	177,039	2,179	0	4,031	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	81,810	0	195,726	0	216,213	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	19,732	0	0	0	6,535	52.00
53.00	05300	ANESTHESIOLOGY	20,775	0	19,407	0	13,602	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	56,104	0	17,790	0	225,232	54.00
56.00	05600	RADIOISOTOPE	2,763	0	217	0	34,397	56.00
60.00	06000	LABORATORY	55,539	0	195,908	0	178,823	60.00
65.00	06500	RESPIRATORY THERAPY	27,287	0	20,695	0	19,243	65.00
66.00	06600	PHYSICAL THERAPY	53,737	0	2,093	0	35,447	66.00
69.00	06900	ELECTROCARDIOLOGY	35,725	0	48,583	0	107,123	69.00
69.01	06901	PULMONARY	0	0	0	0	0	69.01
69.02	06902	CARDIOPULMONARY	2,224	0	272	0	3,099	69.02
69.03	06903	SLEEP LAB	5,744	0	972	0	3,858	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	74,595	0	28,183	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	58,452	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	26,311	0	0	604,685	306,575	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	6,364	0	543	0	2,045	88.00
88.01	08801	RURAL HEALTH CLINIC II	9,104	0	630	0	2,527	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	9,957	0	2,319	0	10,106	90.00
90.01	09001	IMED	0	0	0	0	0	90.01
90.02	09002	ONCOLOGY	52,208	0	7,193	0	59,929	90.02
90.03	09003	OUTPATIENT CENTER	0	0	0	0	0	90.03
90.04	09004	HBURG URGENT CARE CLINIC	21,002	0	2,902	0	11,671	90.04
90.05	09005	DIABETES MGMT CLINIC	1,196	0	125	0	387	90.05
91.00	09100	EMERGENCY	78,300	0	9,997	0	162,647	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	56,279	0	3,057	0	19,596	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
101.00	10100	HOME HEALTH AGENCY	41,446	0	2,006	0	10,403	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)	927,277	1,502,586	638,458	604,685	1,597,159	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	314,849	0	25,911	0	258,382	192.00
192.01	19201	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	14,999	0	72	0	4,003	192.01
194.00	07950	LODGE	100	0	47	0	0	194.00
194.01	07951	OTHER NRCC	0	0	0	0	0	194.01
194.02	07952	MEMORIAL HOSPITAL FOUNDATION	2,416	0	44	0	0	194.02
194.03	07953	MKT/PHY SERVICES	2,559	0	53	0	1,094	194.03
194.04	07954	COMMUNITY EDUCATION	12,302	0	1,635	0	0	194.04
194.05	07955	VOLUNTEER	4,197	0	113	0	0	194.05
194.06	07956	MAB	0	0	0	0	0	194.06
194.07	07957	OFFSITE COVID SCREENING	4,597	0	0	0	0	194.07
194.08	07958	PUBLIC RELATIONS	0	0	0	0	0	194.08

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0115 | Period: From 07/01/2021 To 06/30/2022 | Worksheet B Part I Date/Time Prepared: 11/29/2022 11:30 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
194.09	07959	UNUSED SPACE	0	0	0	0	0	194.09
194.10	07960	EMERGENCY PREPAREDNESS	2,023	0	3,997	0	0	194.10
194.11	07961	HOME OFFICE	0	0	0	0	0	194.11
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)	1,285,319	1,502,586	670,330	604,685	1,860,638	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0115 | Period: From 07/01/2021 To 06/30/2022 | Worksheet B Part I | Date/Time Prepared: 11/29/2022 11:30 am

		Cost Center Description	INTERNS & RESIDENTS: SERVICES-SALARY & FRINGES	INTERNS & RESIDENTS: SERVICES-OTHER PRGM. COSTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			21.00	22.00	24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	1,338,066					21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD		1,936,726				22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	473,156	684,851	13,519,554	-1,158,007	12,361,547	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	6,277,151	0	6,277,151	31.00
40.00	04000	SUBPROVIDER - IPF	16,281	23,565	2,388,923	-39,846	2,349,077	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	1,224,932	0	1,224,932	41.00
43.00	04300	NURSERY	0	0	1,205,523	0	1,205,523	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	2,833,439	0	2,833,439	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	171,964	248,902	19,352,627	-420,866	18,931,761	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	2,217,230	0	2,217,230	52.00
53.00	05300	ANESTHESIOLOGY	0	0	1,546,106	0	1,546,106	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	7,379,276	0	7,379,276	54.00
56.00	05600	RADIOISOTOPE	0	0	1,086,412	0	1,086,412	56.00
60.00	06000	LABORATORY	0	0	11,807,133	0	11,807,133	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	2,710,407	0	2,710,407	65.00
66.00	06600	PHYSICAL THERAPY	0	0	4,260,002	0	4,260,002	66.00
69.00	06900	ELECTROCARDIOLOGY	44,772	64,803	6,627,872	-109,575	6,518,297	69.00
69.01	06901	PULMONARY	0	0	0	0	0	69.01
69.02	06902	CARDIOPULMONARY	44,772	64,803	389,676	-109,575	280,101	69.02
69.03	06903	SLEEP LAB	0	0	497,497	0	497,497	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	1,602,552	0	1,602,552	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	6,464,216	0	6,464,216	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	23,354,761	0	23,354,761	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	774,804	0	774,804	88.00
88.01	08801	RURAL HEALTH CLINIC II	4,070	5,891	993,717	-9,961	983,756	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	1,092,756	0	1,092,756	90.00
90.01	09001	IMED	0	0	0	0	0	90.01
90.02	09002	ONCOLOGY	14,246	20,619	5,308,877	-34,865	5,274,012	90.02
90.03	09003	OUTPATIENT CENTER	0	0	1,292	0	1,292	90.03
90.04	09004	HBURG URGENT CARE CLINIC	41,719	60,385	2,075,958	-102,104	1,973,854	90.04
90.05	09005	DIABETES MGMT CLINIC	0	0	115,170	0	115,170	90.05
91.00	09100	EMERGENCY	78,351	113,405	9,234,657	-191,756	9,042,901	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	3,426,952	0	3,426,952	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
101.00	10100	HOME HEALTH AGENCY	0	0	3,416,465	0	3,416,465	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE			0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	889,331	1,287,224	143,185,937	-2,176,555	141,009,382	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	40,653	0	40,653	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	393,788	569,972	55,011,472	-963,760	54,047,712	192.00
192.01	19201	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	1,405,813	0	1,405,813	192.01
194.00	07950	LODGE	0	0	1,196,773	0	1,196,773	194.00
194.01	07951	OTHER NRCC	0	0	0	0	0	194.01
194.02	07952	MEMORIAL HOSPITAL FOUNDATION	0	0	226,245	0	226,245	194.02
194.03	07953	MKT/PHY SERVICES	0	0	4,438,880	0	4,438,880	194.03
194.04	07954	COMMUNITY EDUCATION	32,561	47,129	987,968	-79,690	908,278	194.04

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0115 | Period: From 07/01/2021 To 06/30/2022 | Worksheet B Part I Date/Time Prepared: 11/29/2022 11:30 am

		Cost Center Description	INTERNS & RESIDENTS		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			SERVICES-SALARY & FRINGES	SERVICES-OTHER PRGM. COSTS				
			21.00	22.00	24.00	25.00	26.00	
194.05	07955	VOLUNTEER	0	0	404,449	0	404,449	194.05
194.06	07956	MAB	0	0	0	0	0	194.06
194.07	07957	OFFSITE COVID SCREENING	0	0	223,434	0	223,434	194.07
194.08	07958	PUBLIC RELATIONS	0	0	124	0	124	194.08
194.09	07959	UNUSED SPACE	0	0	0	0	0	194.09
194.10	07960	EMERGENCY PREPAREDNESS	0	0	1,697,041	0	1,697,041	194.10
194.11	07961	HOME OFFICE	22,386	32,401	9,126,529	-54,787	9,071,742	194.11
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,338,066	1,936,726	217,945,318	-3,274,792	214,670,526	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0115 | Period: From 07/01/2021 To 06/30/2022 | Worksheet B Part II | Date/Time Prepared: 11/29/2022 11:30 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	213,584	157,539	371,123	0	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	4,525	3,337	7,862	0	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	24,517	18,084	42,601	0	8.00
9.00	00900	HOUSEKEEPING	0	0	0	0	0	9.00
10.00	01000	DIETARY	0	24,289	17,915	42,204	0	10.00
11.00	01100	CAFETERIA	0	75,158	55,437	130,595	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	17,050	12,576	29,626	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	14,216	10,486	24,702	0	14.00
15.00	01500	PHARMACY	0	44,704	32,974	77,678	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	63,031	46,491	109,522	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	383,039	282,529	665,568	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	175,866	129,718	305,584	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	138,933	102,477	241,410	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	72,486	53,465	125,951	0	41.00
43.00	04300	NURSERY	0	45,482	33,548	79,030	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	78,829	58,144	136,973	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	522,218	385,186	907,404	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	90,965	67,095	158,060	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	175,620	129,537	305,157	0	54.00
56.00	05600	RADIOISOTOPE	0	11,933	8,802	20,735	0	56.00
60.00	06000	LABORATORY	0	84,757	62,517	147,274	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	31,105	22,943	54,048	0	65.00
66.00	06600	PHYSICAL THERAPY	0	72,655	53,590	126,245	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	165,480	122,058	287,538	0	69.00
69.01	06901	PULMONARY	0	0	0	0	0	69.01
69.02	06902	CARDIOPULMONARY	0	20,568	15,171	35,739	0	69.02
69.03	06903	SLEEP LAB	0	23,629	17,429	41,058	0	69.03
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
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	24,297	17,922	42,219	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	56,054	41,345	97,399	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	71,987	53,097	125,084	0	90.00
90.01	09001	IMED	0	0	0	0	0	90.01
90.02	09002	ONCOLOGY	0	152,761	112,676	265,437	0	90.02
90.03	09003	OUTPATIENT CENTER	0	0	0	0	0	90.03
90.04	09004	HBURG URGENT CARE CLINIC	0	67,522	49,804	117,326	0	90.04
90.05	09005	DIABETES MGMT CLINIC	0	6,969	5,140	12,109	0	90.05
91.00	09100	EMERGENCY	0	135,940	100,269	236,209	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	27,367	20,186	47,553	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
101.00	10100	HOME HEALTH AGENCY	0	31,782	23,442	55,224	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	3,149,318	2,322,929	5,472,247	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	12,593	9,288	21,881	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,292,440	953,300	2,245,740	0	192.00
192.01	19201	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	31,139	22,968	54,107	0	192.01
194.00	07950	LODGE	0	365,305	269,448	634,753	0	194.00
194.01	07951	OTHER NRCC	0	0	0	0	0	194.01
194.02	07952	MEMORIAL HOSPITAL FOUNDATION	0	12,736	9,394	22,130	0	194.02
194.03	07953	MKT/PHY SERVICES	0	1,015	749	1,764	0	194.03
194.04	07954	COMMUNITY EDUCATION	0	62,490	46,092	108,582	0	194.04
194.05	07955	VOLUNTEER	0	0	0	0	0	194.05

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0115 | Period: From 07/01/2021 To 06/30/2022 | Worksheet B Part II Date/Time Prepared: 11/29/2022 11:30 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
194.06	07956	MAB	0	0	0	0	0	194.06
194.07	07957	OFFSITE COVID SCREENING	0	0	0	0	0	194.07
194.08	07958	PUBLIC RELATIONS	0	0	0	0	0	194.08
194.09	07959	UNUSED SPACE	0	0	0	0	0	194.09
194.10	07960	EMERGENCY PREPAREDNESS	0	0	0	0	0	194.10
194.11	07961	HOME OFFICE	0	2,810,101	2,072,719	4,882,820	0	194.11
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	7,737,137	5,706,887	13,444,024	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0115 | Period: From 07/01/2021 To 06/30/2022 | Worksheet B Part II | Date/Time Prepared: 11/29/2022 11:30 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	6.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	371,123					5.00
6.00	00600	MAINTENANCE & REPAIRS	12,230	20,092				6.00
8.00	00800	LAUNDRY & LINEN SERVICE	931	66	43,598			8.00
9.00	00900	HOUSEKEEPING	3,231	0	0	3,231		9.00
10.00	01000	DIETARY	1,004	65	344	10	43,627	10.00
11.00	01100	CAFETERIA	2,034	201	0	32	0	11.00
13.00	01300	NURSING ADMINISTRATION	2,498	46	0	7	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,063	38	1,537	6	0	14.00
15.00	01500	PHARMACY	921	119	0	19	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,168	0	0	0	0	16.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	2,278	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	3,154	168	0	27	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	18,184	1,024	8,504	165	18,421	30.00
31.00	03100	INTENSIVE CARE UNIT	9,231	470	3,240	76	8,864	31.00
40.00	04000	SUBPROVIDER - IPF	3,377	371	643	60	2,650	40.00
41.00	04100	SUBPROVIDER - IRF	1,733	194	847	31	1,899	41.00
43.00	04300	NURSERY	1,746	122	23	20	3,171	43.00
44.00	04400	SKILLED NURSING FACILITY	4,053	211	1,878	34	8,622	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	30,165	1,395	6,857	225	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,491	243	2,317	39	0	52.00
53.00	05300	ANESTHESIOLOGY	2,541	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,575	469	5,322	76	0	54.00
56.00	05600	RADIOISOTOPE	1,761	32	0	5	0	56.00
60.00	06000	LABORATORY	19,192	226	162	37	0	60.00
65.00	06500	RESPIRATORY THERAPY	4,436	83	0	13	0	65.00
66.00	06600	PHYSICAL THERAPY	6,918	194	1,355	31	0	66.00
69.00	06900	ELECTROCARDIOLOGY	10,372	442	2,686	71	0	69.00
69.01	06901	PULMONARY	0	0	0	0	0	69.01
69.02	06902	CARDIOPULMONARY	424	55	41	9	0	69.02
69.03	06903	SLEEP LAB	775	63	251	10	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,553	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	10,906	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	38,167	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,254	65	0	10	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	1,539	150	0	24	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	1,673	192	77	31	0	90.00
90.01	09001	IMED	0	0	0	0	0	90.01
90.02	09002	ONCOLOGY	8,439	408	1,009	66	0	90.02
90.03	09003	OUTPATIENT CENTER	0	0	99	0	0	90.03
90.04	09004	HBURG URGENT CARE CLINIC	3,025	180	6,100	29	0	90.04
90.05	09005	DIABETES MGMT CLINIC	179	19	0	3	0	90.05
91.00	09100	EMERGENCY	14,689	363	0	59	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	5,644	73	3	12	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
101.00	10100	HOME HEALTH AGENCY	5,660	85	0	14	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)	256,214	7,832	43,295	1,251	43,627	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	43	34	0	5	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	88,389	3,454	303	557	0	192.00
192.01	19201	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	2,297	83	0	13	0	192.01
194.00	07950	LODGE	1,286	976	0	157	0	194.00
194.01	07951	OTHER NRCC	0	0	0	0	0	194.01
194.02	07952	MEMORIAL HOSPITAL FOUNDATION	355	34	0	5	0	194.02
194.03	07953	MKT/PHY SERVICES	7,549	3	0	0	0	194.03
194.04	07954	COMMUNITY EDUCATION	1,394	167	0	27	0	194.04
194.05	07955	VOLUNTEER	681	0	0	0	0	194.05
194.06	07956	MAB	0	0	0	0	0	194.06
194.07	07957	OFFSITE COVID SCREENING	373	0	0	0	0	194.07
194.08	07958	PUBLIC RELATIONS	0	0	0	0	0	194.08
194.09	07959	UNUSED SPACE	0	0	0	0	0	194.09

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0115 | Period: From 07/01/2021 To 06/30/2022 | Worksheet B Part II Date/Time Prepared: 11/29/2022 11:30 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	6.00	8.00	9.00	10.00	
194.10	07960	EMERGENCY PREPAREDNESS	2,879	0	0	0	0	194.10
194.11	07961	HOME OFFICE	9,663	7,509	0	1,216	0	194.11
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)	371,123	20,092	43,598	3,231	43,627	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0115 | Period: From 07/01/2021 To 06/30/2022 | Worksheet B Part II | Date/Time Prepared: 11/29/2022 11:30 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	132,862					11.00
13.00	01300	NURSING ADMINISTRATION	1,537	33,714				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	909	0	28,255			14.00
15.00	01500	PHARMACY	524	0	185	79,446		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	3,168	16.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	820	0	3	0	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	10,692	15,362	859	0	54	30.00
31.00	03100	INTENSIVE CARE UNIT	5,986	8,600	225	0	41	31.00
40.00	04000	SUBPROVIDER - IPF	1,961	2,817	27	0	9	40.00
41.00	04100	SUBPROVIDER - IRF	1,043	1,498	19	0	6	41.00
43.00	04300	NURSERY	1,020	1,465	0	0	7	43.00
44.00	04400	SKILLED NURSING FACILITY	2,765	3,972	92	0	6	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,457	0	8,250	0	331	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,040	0	0	0	10	52.00
53.00	05300	ANESTHESIOLOGY	2,148	0	818	0	21	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,799	0	750	0	344	54.00
56.00	05600	RADIOISOTOPE	286	0	9	0	53	56.00
60.00	06000	LABORATORY	5,741	0	8,258	0	273	60.00
65.00	06500	RESPIRATORY THERAPY	2,821	0	872	0	29	65.00
66.00	06600	PHYSICAL THERAPY	5,555	0	88	0	54	66.00
69.00	06900	ELECTROCARDIOLOGY	3,693	0	2,048	0	164	69.00
69.01	06901	PULMONARY	0	0	0	0	0	69.01
69.02	06902	CARDIOPULMONARY	230	0	11	0	5	69.02
69.03	06903	SLEEP LAB	594	0	41	0	6	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	3,144	0	43	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	89	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,720	0	0	79,446	792	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	658	0	23	0	3	88.00
88.01	08801	RURAL HEALTH CLINIC II	941	0	27	0	4	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	1,029	0	98	0	15	90.00
90.01	09001	IMED	0	0	0	0	0	90.01
90.02	09002	ONCOLOGY	5,397	0	303	0	92	90.02
90.03	09003	OUTPATIENT CENTER	0	0	0	0	0	90.03
90.04	09004	HBURG URGENT CARE CLINIC	2,171	0	122	0	18	90.04
90.05	09005	DIABETES MGMT CLINIC	124	0	5	0	1	90.05
91.00	09100	EMERGENCY	8,094	0	421	0	249	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	5,817	0	129	0	30	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
101.00	10100	HOME HEALTH AGENCY	4,284	0	85	0	16	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)	95,856	33,714	26,912	79,446	2,765	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	32,542	0	1,092	0	395	192.00
192.01	19201	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1,550	0	3	0	6	192.01
194.00	07950	LODGE	10	0	2	0	0	194.00
194.01	07951	OTHER NRCC	0	0	0	0	0	194.01
194.02	07952	MEMORIAL HOSPITAL FOUNDATION	250	0	2	0	0	194.02
194.03	07953	MKT/PHY SERVICES	264	0	2	0	2	194.03
194.04	07954	COMMUNITY EDUCATION	1,272	0	69	0	0	194.04
194.05	07955	VOLUNTEER	434	0	5	0	0	194.05
194.06	07956	MAB	0	0	0	0	0	194.06
194.07	07957	OFFSITE COVID SCREENING	475	0	0	0	0	194.07
194.08	07958	PUBLIC RELATIONS	0	0	0	0	0	194.08

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0115 | Period: From 07/01/2021 To 06/30/2022 | Worksheet B Part II Date/Time Prepared: 11/29/2022 11:30 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
194.09	07959	UNUSED SPACE	0	0	0	0	0	194.09
194.10	07960	EMERGENCY PREPAREDNESS	209	0	168	0	0	194.10
194.11	07961	HOME OFFICE	0	0	0	0	0	194.11
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)	132,862	33,714	28,255	79,446	3,168	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0115 | Period: From 07/01/2021 To 06/30/2022 | Worksheet B Part II | Date/Time Prepared: 11/29/2022 11:30 am

		Cost Center Description	INTERNS & RESIDENTS		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			SERVICES-SALARY & FRINGES	SERVICES-OTHER PRGM. COSTS				
			21.00	22.00	24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	2,278					21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD		113,694				22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS			738,833	0	738,833	30.00
31.00	03100	INTENSIVE CARE UNIT			342,317	0	342,317	31.00
40.00	04000	SUBPROVIDER - IPF			253,325	0	253,325	40.00
41.00	04100	SUBPROVIDER - IRF			133,221	0	133,221	41.00
43.00	04300	NURSERY			86,604	0	86,604	43.00
44.00	04400	SKILLED NURSING FACILITY			158,606	0	158,606	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM			963,084	0	963,084	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM			166,200	0	166,200	52.00
53.00	05300	ANESTHESIOLOGY			5,528	0	5,528	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC			329,492	0	329,492	54.00
56.00	05600	RADIOISOTOPE			22,881	0	22,881	56.00
60.00	06000	LABORATORY			181,163	0	181,163	60.00
65.00	06500	RESPIRATORY THERAPY			62,302	0	62,302	65.00
66.00	06600	PHYSICAL THERAPY			140,440	0	140,440	66.00
69.00	06900	ELECTROCARDIOLOGY			307,014	0	307,014	69.00
69.01	06901	PULMONARY			0	0	0	69.01
69.02	06902	CARDIOPULMONARY			36,514	0	36,514	69.02
69.03	06903	SLEEP LAB			42,798	0	42,798	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY			0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS			5,740	0	5,740	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS			10,995	0	10,995	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS			121,125	0	121,125	73.00
74.00	07400	RENAL DIALYSIS			0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC			44,232	0	44,232	88.00
88.01	08801	RURAL HEALTH CLINIC II			100,084	0	100,084	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER			0	0	0	89.00
90.00	09000	CLINIC			128,199	0	128,199	90.00
90.01	09001	IMED			0	0	0	90.01
90.02	09002	ONCOLOGY			281,151	0	281,151	90.02
90.03	09003	OUTPATIENT CENTER			99	0	99	90.03
90.04	09004	HBURG URGENT CARE CLINIC			128,971	0	128,971	90.04
90.05	09005	DIABETES MGMT CLINIC			12,440	0	12,440	90.05
91.00	09100	EMERGENCY			260,084	0	260,084	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES			59,261	0	59,261	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED			0	0	0	96.00
101.00	10100	HOME HEALTH AGENCY			65,368	0	65,368	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE			0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	0	5,188,071	0	5,188,071	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN			21,963	0	21,963	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES			2,372,472	0	2,372,472	192.00
192.01	19201	PSYCHIATRIC/PSYCHOLOGICAL SERVICES			58,059	0	58,059	192.01
194.00	07950	LODGE			637,184	0	637,184	194.00
194.01	07951	OTHER NRCC			0	0	0	194.01
194.02	07952	MEMORIAL HOSPITAL FOUNDATION			22,776	0	22,776	194.02
194.03	07953	MKT/PHY SERVICES			9,584	0	9,584	194.03
194.04	07954	COMMUNITY EDUCATION			111,511	0	111,511	194.04

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0115 | Period: From 07/01/2021 To 06/30/2022 | Worksheet B Part II Date/Time Prepared: 11/29/2022 11:30 am

		Cost Center Description	INTERNS & RESIDENTS		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			SERVICES-SALARY & FRINGES	SERVICES-OTHER PRGM. COSTS				
			21.00	22.00	24.00	25.00	26.00	
194.05	07955	VOLUNTEER			1,120	0	1,120	194.05
194.06	07956	MAB			0	0	0	194.06
194.07	07957	OFFSITE COVID SCREENING			848	0	848	194.07
194.08	07958	PUBLIC RELATIONS			0	0	0	194.08
194.09	07959	UNUSED SPACE			0	0	0	194.09
194.10	07960	EMERGENCY PREPAREDNESS			3,256	0	3,256	194.10
194.11	07961	HOME OFFICE			4,901,208	0	4,901,208	194.11
200.00		Cross Foot Adjustments	2,278	113,694	115,972	0	115,972	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	2,278	113,694	13,444,024	0	13,444,024	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0115 | Period: From 07/01/2021 To 06/30/2022 | Worksheet B-1 | Date/Time Prepared: 11/29/2022 11:30 am

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	914,868					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		914,868				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	98,465,018			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	25,255	25,255	1,427,729	-30,444,235	187,501,083	5.00
6.00	00600	MAINTENANCE & REPAIRS	535	535	537,884	0	6,179,675	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,899	2,899	283,996	0	470,273	8.00
9.00	00900	HOUSEKEEPING	0	0	0	0	1,632,661	9.00
10.00	01000	DIETARY	2,872	2,872	235,909	0	507,151	10.00
11.00	01100	CAFETERIA	8,887	8,887	814,734	0	1,027,632	11.00
13.00	01300	NURSING ADMINISTRATION	2,016	2,016	920,454	0	1,262,177	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,681	1,681	283,170	0	537,060	14.00
15.00	01500	PHARMACY	5,286	5,286	324,485	0	465,602	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	1,600,731	16.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	1,151,155	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	7,453	7,453	1,321,234	0	1,593,782	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	45,292	45,292	5,732,611	0	9,188,302	30.00
31.00	03100	INTENSIVE CARE UNIT	20,795	20,795	3,328,433	0	4,664,555	31.00
40.00	04000	SUBPROVIDER - IPF	16,428	16,428	1,272,350	0	1,706,540	40.00
41.00	04100	SUBPROVIDER - IRF	8,571	8,571	547,932	0	875,846	41.00
43.00	04300	NURSERY	5,378	5,378	583,454	0	882,133	43.00
44.00	04400	SKILLED NURSING FACILITY	9,321	9,321	1,372,477	0	2,047,921	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	61,749	61,749	5,170,004	0	15,242,359	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	10,756	10,756	1,166,909	0	1,764,267	52.00
53.00	05300	ANESTHESIOLOGY	0	0	3,578,532	0	1,283,864	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	20,766	20,766	6,494,098	0	5,848,684	54.00
56.00	05600	RADIOISOTOPE	1,411	1,411	181,502	0	890,091	56.00
60.00	06000	LABORATORY	10,022	10,022	3,204,880	0	9,697,718	60.00
65.00	06500	RESPIRATORY THERAPY	3,678	3,678	1,342,887	0	2,241,623	65.00
66.00	06600	PHYSICAL THERAPY	8,591	8,591	2,797,711	0	3,495,620	66.00
69.00	06900	ELECTROCARDIOLOGY	19,567	19,567	2,600,520	0	5,240,816	69.00
69.01	06901	PULMONARY	0	0	0	0	0	69.01
69.02	06902	CARDIOPULMONARY	2,432	2,432	100,996	0	214,318	69.02
69.03	06903	SLEEP LAB	2,794	2,794	253,392	0	391,510	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	1,290,275	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	5,510,960	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	1,638,955	0	19,285,794	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,873	2,873	383,179	0	633,609	88.00
88.01	08801	RURAL HEALTH CLINIC II	6,628	6,628	493,586	0	777,509	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	8,512	8,512	493,855	0	845,145	90.00
90.01	09001	IMED	0	0	0	0	0	90.01
90.02	09002	ONCOLOGY	18,063	18,063	2,433,807	0	4,264,459	90.02
90.03	09003	OUTPATIENT CENTER	0	0	0	0	0	90.03
90.04	09004	HBURG URGENT CARE CLINIC	7,984	7,984	1,200,456	0	1,528,705	90.04
90.05	09005	DIABETES MGMT CLINIC	824	824	60,564	0	90,367	90.05
91.00	09100	EMERGENCY	16,074	16,074	9,608,388	0	7,422,494	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	3,236	3,236	2,404,222	0	2,851,853	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
101.00	10100	HOME HEALTH AGENCY	3,758	3,758	1,986,817	0	2,859,852	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)	372,387	372,387	66,582,112	-30,444,235	129,465,088	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,489	1,489	0	0	21,881	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	152,823	152,823	29,848,927	0	44,635,251	192.00
192.01	19201	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	3,682	3,682	857,964	0	1,160,653	192.01
194.00	07950	LODGE	43,195	43,195	2,744	0	649,658	194.00
194.01	07951	OTHER NRCC	0	0	0	0	0	194.01
194.02	07952	MEMORIAL HOSPITAL FOUNDATION	1,506	1,506	121,556	0	179,283	194.02
194.03	07953	MKT/PHY SERVICES	120	120	232,157	0	3,814,581	194.03
194.04	07954	COMMUNITY EDUCATION	7,389	7,389	381,336	0	704,441	194.04

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0115 | Period: From 07/01/2021 To 06/30/2022 | Worksheet B-1 | Date/Time Prepared: 11/29/2022 11:30 am

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
194.05	07955	VOLUNTEER	0	0	253,717	0	344,245	194.05
194.06	07956	MAB	0	0	0	0	0	194.06
194.07	07957	OFFSITE COVID SCREENING	0	0	138,034	0	188,268	194.07
194.08	07958	PUBLIC RELATIONS	0	0	0	0	107	194.08
194.09	07959	UNUSED SPACE	0	0	0	0	0	194.09
194.10	07960	EMERGENCY PREPAREDNESS	0	0	46,471	0	1,454,807	194.10
194.11	07961	HOME OFFICE	332,277	332,277	0	0	4,882,820	194.11
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)	7,737,137	5,706,887	25,261,293		30,444,235	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	8.457107	6.237935	0.256551		0.162368	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			0		371,123	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000000		0.001979	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: 15-0115 | Period: From 07/01/2021 To 06/30/2022 | Worksheet B-1 | Date/Time Prepared: 11/29/2022 11:30 am

		Cost Center Description	MAINTENANCE & REPAIRS (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	CAFETERIA (HOURS)	
			6.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS	889,078					6.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,899	804,736				8.00
9.00	00900	HOUSEKEEPING	0	0	886,179			9.00
10.00	01000	DIETARY	2,872	6,343	2,872	22,011		10.00
11.00	01100	CAFETERIA	8,887	0	8,887	0	1,992,318	11.00
13.00	01300	NURSING ADMINISTRATION	2,016	0	2,016	0	23,045	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,681	28,361	1,681	0	13,638	14.00
15.00	01500	PHARMACY	5,286	0	5,286	0	7,864	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	7,453	0	7,453	0	12,292	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	45,292	156,958	45,292	9,294	160,325	30.00
31.00	03100	INTENSIVE CARE UNIT	20,795	59,803	20,795	4,472	89,756	31.00
40.00	04000	SUBPROVIDER - IPF	16,428	11,870	16,428	1,337	29,399	40.00
41.00	04100	SUBPROVIDER - IRF	8,571	15,640	8,571	958	15,636	41.00
43.00	04300	NURSERY	5,378	432	5,378	1,600	15,293	43.00
44.00	04400	SKILLED NURSING FACILITY	9,321	34,656	9,321	4,350	41,458	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	61,749	126,575	61,749	0	126,811	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	10,756	42,775	10,756	0	30,586	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	32,203	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	20,766	98,231	20,766	0	86,964	54.00
56.00	05600	RADIOISOTOPE	1,411	0	1,411	0	4,283	56.00
60.00	06000	LABORATORY	10,022	2,985	10,022	0	86,088	60.00
65.00	06500	RESPIRATORY THERAPY	3,678	0	3,678	0	42,296	65.00
66.00	06600	PHYSICAL THERAPY	8,591	25,016	8,591	0	83,296	66.00
69.00	06900	ELECTROCARDIOLOGY	19,567	49,578	19,567	0	55,376	69.00
69.01	06901	PULMONARY	0	0	0	0	0	69.01
69.02	06902	CARDIOPULMONARY	2,432	752	2,432	0	3,448	69.02
69.03	06903	SLEEP LAB	2,794	4,641	2,794	0	8,903	69.03
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	40,783	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,873	0	2,873	0	9,865	88.00
88.01	08801	RURAL HEALTH CLINIC II	6,628	0	6,628	0	14,111	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	8,512	1,420	8,512	0	15,434	90.00
90.01	09001	IMED	0	0	0	0	0	90.01
90.02	09002	ONCOLOGY	18,063	18,626	18,063	0	80,926	90.02
90.03	09003	OUTPATIENT CENTER	0	1,824	0	0	0	90.03
90.04	09004	HBURG URGENT CARE CLINIC	7,984	112,595	7,984	0	32,554	90.04
90.05	09005	DIABETES MGMT CLINIC	824	0	824	0	1,854	90.05
91.00	09100	EMERGENCY	16,074	0	16,074	0	121,369	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	3,236	60	3,236	0	87,235	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
101.00	10100	HOME HEALTH AGENCY	3,758	0	3,758	0	64,244	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)	346,597	799,141	343,698	22,011	1,437,335	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,489	0	1,489	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	152,823	5,595	152,823	0	488,032	192.00
192.01	19201	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	3,682	0	3,682	0	23,250	192.01
194.00	07950	LODGE	43,195	0	43,195	0	155	194.00
194.01	07951	OTHER NRCC	0	0	0	0	0	194.01
194.02	07952	MEMORIAL HOSPITAL FOUNDATION	1,506	0	1,506	0	3,745	194.02
194.03	07953	MKT/PHY SERVICES	120	0	120	0	3,966	194.03
194.04	07954	COMMUNITY EDUCATION	7,389	0	7,389	0	19,069	194.04
194.05	07955	VOLUNTEER	0	0	0	0	6,505	194.05
194.06	07956	MAB	0	0	0	0	0	194.06
194.07	07957	OFFSITE COVID SCREENING	0	0	0	0	7,126	194.07

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0115 | Period: From 07/01/2021 To 06/30/2022 | Worksheet B-1 | Date/Time Prepared: 11/29/2022 11:30 am

		Cost Center Description	MAINTENANCE & REPAIRS (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	CAFETERIA (HOURS)	
			6.00	8.00	9.00	10.00	11.00	
194.08	07958	PUBLIC RELATIONS	0	0	0	0	0	194.08
194.09	07959	UNUSED SPACE	0	0	0	0	0	194.09
194.10	07960	EMERGENCY PREPAREDNESS	0	0	0	0	3,135	194.10
194.11	07961	HOME OFFICE	332,277	0	332,277	0	0	194.11
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)	7,183,056	570,052	1,897,753	623,343	1,285,319	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	8.079219	0.708371	2.141501	28.319613	0.645137	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	20,092	43,598	3,231	43,627	132,862	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.022599	0.054177	0.003646	1.982054	0.066687	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: 15-0115 | Period: From 07/01/2021 To 06/30/2022 | Worksheet B-1 | Date/Time Prepared: 11/29/2022 11:30 am

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (REVENUE)	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES (ASSIGNED TIME)	
			13.00	14.00	15.00	16.00	21.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	351,867					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	11,594,717				14.00
15.00	01500	PHARMACY	0	75,823	100			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	711,313,505		16.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	1,315	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	1,038	0	0		22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	160,325	352,296	0	13,614,480	465	30.00
31.00	03100	INTENSIVE CARE UNIT	89,756	92,468	0	10,372,952	0	31.00
40.00	04000	SUBPROVIDER - IPF	29,399	11,146	0	2,339,364	16	40.00
41.00	04100	SUBPROVIDER - IRF	15,636	7,747	0	1,437,174	0	41.00
43.00	04300	NURSERY	15,293	0	0	1,683,626	0	43.00
44.00	04400	SKILLED NURSING FACILITY	41,458	37,687	0	1,540,884	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	3,385,497	0	82,650,261	169	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	2,497,981	0	52.00
53.00	05300	ANESTHESIOLOGY	0	335,692	0	5,199,573	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	307,710	0	86,098,048	0	54.00
56.00	05600	RADIOISOTOPE	0	3,755	0	13,148,867	0	56.00
60.00	06000	LABORATORY	0	3,388,586	0	68,357,497	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	357,972	0	7,355,820	0	65.00
66.00	06600	PHYSICAL THERAPY	0	36,198	0	13,549,969	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	840,355	0	40,949,085	44	69.00
69.01	06901	PULMONARY	0	0	0	0	0	69.01
69.02	06902	CARDIOPULMONARY	0	4,704	0	1,184,646	44	69.02
69.03	06903	SLEEP LAB	0	16,819	0	1,474,855	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,290,275	0	10,773,185	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	22,343,956	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	100	117,252,690	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	9,391	0	781,635	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	10,903	0	965,869	4	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	40,117	0	3,863,263	0	90.00
90.01	09001	IMED	0	0	0	0	0	90.01
90.02	09002	ONCOLOGY	0	124,421	0	22,908,637	14	90.02
90.03	09003	OUTPATIENT CENTER	0	0	0	0	0	90.03
90.04	09004	HBURG URGENT CARE CLINIC	0	50,196	0	4,461,499	41	90.04
90.05	09005	DIABETES MGMT CLINIC	0	2,156	0	147,842	0	90.05
91.00	09100	EMERGENCY	0	172,920	0	62,173,999	77	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	52,873	0	7,490,900	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
101.00	10100	HOME HEALTH AGENCY	0	34,693	0	3,976,571	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	351,867	11,043,438	100	610,595,128	874	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	448,181	0	98,769,826	387	192.00
192.01	19201	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	1,246	0	1,530,321	0	192.01
194.00	07950	LODGE	0	816	0	0	0	194.00
194.01	07951	OTHER NRCC	0	0	0	0	0	194.01
194.02	07952	MEMORIAL HOSPITAL FOUNDATION	0	762	0	0	0	194.02
194.03	07953	MKT/PHY SERVICES	0	911	0	418,230	0	194.03
194.04	07954	COMMUNITY EDUCATION	0	28,278	0	0	32	194.04

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0115 | Period: From 07/01/2021 To 06/30/2022 | Worksheet B-1 | Date/Time Prepared: 11/29/2022 11:30 am

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (REVENUE)	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES (ASSIGNED TIME)	
			13.00	14.00	15.00	16.00	21.00	
194.05	07955	VOLUNTEER	0	1,946	0	0	0	194.05
194.06	07956	MAB	0	0	0	0	0	194.06
194.07	07957	OFFSITE COVID SCREENING	0	0	0	0	0	194.07
194.08	07958	PUBLIC RELATIONS	0	0	0	0	0	194.08
194.09	07959	UNUSED SPACE	0	0	0	0	0	194.09
194.10	07960	EMERGENCY PREPAREDNESS	0	69,139	0	0	0	194.10
194.11	07961	HOME OFFICE	0	0	0	0	22	194.11
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)	1,502,586	670,330	604,685	1,860,638	1,338,066	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	4.270324	0.057813	6,046.850000	0.002616	1,017.540684	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	33,714	28,255	79,446	3,168	2,278	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.095815	0.002437	794.460000	0.000004	1.732319	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: 15-0115 | Period: From 07/01/2021 To 06/30/2022 | Worksheet B-1 | Date/Time Prepared: 11/29/2022 11:30 am

		Cost Center Description	INTERNS & RESIDENTS SERVICES-OTHER PRGM. COSTS (ASSIGNED TIME)		
			22.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
6.00	00600	MAINTENANCE & REPAIRS			6.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD			21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	1,315		22.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	465		30.00
31.00	03100	INTENSIVE CARE UNIT	0		31.00
40.00	04000	SUBPROVIDER - IPF	16		40.00
41.00	04100	SUBPROVIDER - IRF	0		41.00
43.00	04300	NURSERY	0		43.00
44.00	04400	SKILLED NURSING FACILITY	0		44.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	169		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		52.00
53.00	05300	ANESTHESIOLOGY	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0		54.00
56.00	05600	RADIOISOTOPE	0		56.00
60.00	06000	LABORATORY	0		60.00
65.00	06500	RESPIRATORY THERAPY	0		65.00
66.00	06600	PHYSICAL THERAPY	0		66.00
69.00	06900	ELECTROCARDIOLOGY	44		69.00
69.01	06901	PULMONARY	0		69.01
69.02	06902	CARDIOPULMONARY	44		69.02
69.03	06903	SLEEP LAB	0		69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0		73.00
74.00	07400	RENAL DIALYSIS	0		74.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0		88.00
88.01	08801	RURAL HEALTH CLINIC II	4		88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		89.00
90.00	09000	CLINIC	0		90.00
90.01	09001	IMED	0		90.01
90.02	09002	ONCOLOGY	14		90.02
90.03	09003	OUTPATIENT CENTER	0		90.03
90.04	09004	HBURG URGENT CARE CLINIC	41		90.04
90.05	09005	DIABETES MGMT CLINIC	0		90.05
91.00	09100	EMERGENCY	77		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0		95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0		96.00
101.00	10100	HOME HEALTH AGENCY	0		101.00
		SPECIAL PURPOSE COST CENTERS			
116.00	11600	HOSPICE			116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	874		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	387		192.00
192.01	19201	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0		192.01
194.00	07950	LODGE	0		194.00
194.01	07951	OTHER NRCC	0		194.01
194.02	07952	MEMORIAL HOSPITAL FOUNDATION	0		194.02
194.03	07953	MKT/PHY SERVICES	0		194.03
194.04	07954	COMMUNITY EDUCATION	32		194.04
194.05	07955	VOLUNTEER	0		194.05

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0115 | Period: From 07/01/2021 To 06/30/2022 | Worksheet B-1 | Date/Time Prepared: 11/29/2022 11:30 am

		Cost Center Description	INTERNS & RESIDENTS SERVICES-OTHER PRGM. COSTS (ASSIGNED TIME) 22.00		
194.06	07956	MAB	0		194.06
194.07	07957	OFFSITE COVID SCREENING	0		194.07
194.08	07958	PUBLIC RELATIONS	0		194.08
194.09	07959	UNUSED SPACE	0		194.09
194.10	07960	EMERGENCY PREPAREDNESS	0		194.10
194.11	07961	HOME OFFICE	22		194.11
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)	1,936,726		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	1,472.795437		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	113,694		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	86.459316		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: 15-0115 | Period: From 07/01/2021 To 06/30/2022 | Worksheet C Part I Date/Time Prepared: 11/29/2022 11:30 am

Title XVIII | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	12,361,547		12,361,547	0	12,361,547	30.00
31.00	03100	INTENSIVE CARE UNIT	6,277,151		6,277,151	0	6,277,151	31.00
40.00	04000	SUBPROVIDER - IPF	2,349,077		2,349,077	0	2,349,077	40.00
41.00	04100	SUBPROVIDER - IRF	1,224,932		1,224,932	0	1,224,932	41.00
43.00	04300	NURSERY	1,205,523		1,205,523	0	1,205,523	43.00
44.00	04400	SKILLED NURSING FACILITY	2,833,439		2,833,439	0	2,833,439	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	18,931,761		18,931,761	0	18,931,761	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,217,230		2,217,230	0	2,217,230	52.00
53.00	05300	ANESTHESIOLOGY	1,546,106		1,546,106	0	1,546,106	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,379,276		7,379,276	0	7,379,276	54.00
56.00	05600	RADIOISOTOPE	1,086,412		1,086,412	0	1,086,412	56.00
60.00	06000	LABORATORY	11,807,133		11,807,133	0	11,807,133	60.00
65.00	06500	RESPIRATORY THERAPY	2,710,407	0	2,710,407	0	2,710,407	65.00
66.00	06600	PHYSICAL THERAPY	4,260,002	0	4,260,002	0	4,260,002	66.00
69.00	06900	ELECTROCARDIOLOGY	6,518,297		6,518,297	0	6,518,297	69.00
69.01	06901	PULMONARY	0		0	0	0	69.01
69.02	06902	CARDIOPULMONARY	280,101		280,101	0	280,101	69.02
69.03	06903	SLEEP LAB	497,497		497,497	0	497,497	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,602,552		1,602,552	0	1,602,552	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,464,216		6,464,216	0	6,464,216	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	23,354,761		23,354,761	0	23,354,761	73.00
74.00	07400	RENAL DIALYSIS	0		0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	774,804		774,804	0	774,804	88.00
88.01	08801	RURAL HEALTH CLINIC II	983,756		983,756	0	983,756	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
90.00	09000	CLINIC	1,092,756		1,092,756	0	1,092,756	90.00
90.01	09001	IMED	0		0	0	0	90.01
90.02	09002	ONCOLOGY	5,274,012		5,274,012	0	5,274,012	90.02
90.03	09003	OUTPATIENT CENTER	1,292		1,292	0	1,292	90.03
90.04	09004	HBURG URGENT CARE CLINIC	1,973,854		1,973,854	0	1,973,854	90.04
90.05	09005	DIABETES MGMT CLINIC	115,170		115,170	0	115,170	90.05
91.00	09100	EMERGENCY	9,042,901		9,042,901	0	9,042,901	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	3,455,561		3,455,561		3,455,561	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	3,426,952		3,426,952	0	3,426,952	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0		0	0	0	96.00
101.00	10100	HOME HEALTH AGENCY	3,416,465		3,416,465		3,416,465	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0		0		0	116.00
200.00		Subtotal (see instructions)	144,464,943	0	144,464,943	0	144,464,943	200.00
201.00		Less Observation Beds	3,455,561		3,455,561		3,455,561	201.00
202.00		Total (see instructions)	141,009,382	0	141,009,382	0	141,009,382	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0115 | Period: From 07/01/2021 To 06/30/2022 | Worksheet C Part I | Date/Time Prepared: 11/29/2022 11:30 am

Title XVIII | Hospital | PPS

		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	13,614,480		13,614,480			30.00
31.00	03100	INTENSIVE CARE UNIT	10,372,952		10,372,952			31.00
40.00	04000	SUBPROVIDER - IPF	2,339,364		2,339,364			40.00
41.00	04100	SUBPROVIDER - IRF	1,437,174		1,437,174			41.00
43.00	04300	NURSERY	1,683,626		1,683,626			43.00
44.00	04400	SKILLED NURSING FACILITY	1,540,884		1,540,884			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	9,345,074	73,305,187	82,650,261	0.229059	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,466,544	31,437	2,497,981	0.887609	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	906,929	4,292,644	5,199,573	0.297352	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,759,836	75,338,212	86,098,048	0.085708	0.000000	54.00
56.00	05600	RADIOISOTOPE	379,277	12,769,590	13,148,867	0.082624	0.000000	56.00
60.00	06000	LABORATORY	11,771,586	56,585,911	68,357,497	0.172726	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	2,625,334	4,730,486	7,355,820	0.368471	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	6,466,461	7,083,508	13,549,969	0.314392	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	12,843,512	28,105,573	40,949,085	0.159181	0.000000	69.00
69.01	06901	PULMONARY	0	0	0	0.000000	0.000000	69.01
69.02	06902	CARDIOPULMONARY	1,053	1,183,593	1,184,646	0.236443	0.000000	69.02
69.03	06903	SLEEP LAB	0	1,474,855	1,474,855	0.337319	0.000000	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,606,010	8,167,175	10,773,185	0.148754	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,648,818	15,695,138	22,343,956	0.289305	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	31,245,282	86,007,408	117,252,690	0.199183	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0.000000	0.000000	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	781,635	781,635			88.00
88.01	08801	RURAL HEALTH CLINIC II	0	965,869	965,869			88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0			89.00
90.00	09000	CLINIC	81,214	3,782,049	3,863,263	0.282858	0.000000	90.00
90.01	09001	IMED	0	0	0	0.000000	0.000000	90.01
90.02	09002	ONCOLOGY	157,776	22,750,861	22,908,637	0.230219	0.000000	90.02
90.03	09003	OUTPATIENT CENTER	0	0	0	0.000000	0.000000	90.03
90.04	09004	HBURG URGENT CARE CLINIC	7,936	4,453,563	4,461,499	0.442419	0.000000	90.04
90.05	09005	DIABETES MGMT CLINIC	0	147,842	147,842	0.779007	0.000000	90.05
91.00	09100	EMERGENCY	10,627,613	51,546,386	62,173,999	0.145445	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,153,962	7,544,425	8,698,387	0.397265	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,279,371	6,211,529	7,490,900	0.457482	0.000000	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0.000000	0.000000	96.00
101.00	10100	HOME HEALTH AGENCY	0	3,976,571	3,976,571			101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0			116.00
200.00		Subtotal (see instructions)	142,362,068	476,931,447	619,293,515			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	142,362,068	476,931,447	619,293,515			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0115 | Period: From 07/01/2021 To 06/30/2022 | Worksheet C Part I Date/Time Prepared: 11/29/2022 11:30 am

Title XVIII | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
40.00	04000	SUBPROVIDER - IPF		40.00
41.00	04100	SUBPROVIDER - IRF		41.00
43.00	04300	NURSERY		43.00
44.00	04400	SKILLED NURSING FACILITY		44.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.229059	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.887609	52.00
53.00	05300	ANESTHESIOLOGY	0.297352	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.085708	54.00
56.00	05600	RADIOISOTOPE	0.082624	56.00
60.00	06000	LABORATORY	0.172726	60.00
65.00	06500	RESPIRATORY THERAPY	0.368471	65.00
66.00	06600	PHYSICAL THERAPY	0.314392	66.00
69.00	06900	ELECTROCARDIOLOGY	0.159181	69.00
69.01	06901	PULMONARY	0.000000	69.01
69.02	06902	CARDIOPULMONARY	0.236443	69.02
69.03	06903	SLEEP LAB	0.337319	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.148754	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.289305	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.199183	73.00
74.00	07400	RENAL DIALYSIS	0.000000	74.00
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC		88.00
88.01	08801	RURAL HEALTH CLINIC II		88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER		89.00
90.00	09000	CLINIC	0.282858	90.00
90.01	09001	IMED	0.000000	90.01
90.02	09002	ONCOLOGY	0.230219	90.02
90.03	09003	OUTPATIENT CENTER	0.000000	90.03
90.04	09004	HBURG URGENT CARE CLINIC	0.442419	90.04
90.05	09005	DIABETES MGMT CLINIC	0.779007	90.05
91.00	09100	EMERGENCY	0.145445	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.397265	92.00
		OTHER REIMBURSABLE COST CENTERS		
95.00	09500	AMBULANCE SERVICES	0.457482	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	96.00
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: 15-0115 | Period: From 07/01/2021 To 06/30/2022 | Worksheet C Part I Date/Time Prepared: 11/29/2022 11:30 am

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	12,361,547		12,361,547	0	12,361,547	30.00
31.00	03100	INTENSIVE CARE UNIT	6,277,151		6,277,151	0	6,277,151	31.00
40.00	04000	SUBPROVIDER - IPF	2,349,077		2,349,077	0	2,349,077	40.00
41.00	04100	SUBPROVIDER - IRF	1,224,932		1,224,932	0	1,224,932	41.00
43.00	04300	NURSERY	1,205,523		1,205,523	0	1,205,523	43.00
44.00	04400	SKILLED NURSING FACILITY	2,833,439		2,833,439	0	2,833,439	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	18,931,761		18,931,761	0	18,931,761	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,217,230		2,217,230	0	2,217,230	52.00
53.00	05300	ANESTHESIOLOGY	1,546,106		1,546,106	0	1,546,106	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,379,276		7,379,276	0	7,379,276	54.00
56.00	05600	RADIOISOTOPE	1,086,412		1,086,412	0	1,086,412	56.00
60.00	06000	LABORATORY	11,807,133		11,807,133	0	11,807,133	60.00
65.00	06500	RESPIRATORY THERAPY	2,710,407	0	2,710,407	0	2,710,407	65.00
66.00	06600	PHYSICAL THERAPY	4,260,002	0	4,260,002	0	4,260,002	66.00
69.00	06900	ELECTROCARDIOLOGY	6,518,297		6,518,297	0	6,518,297	69.00
69.01	06901	PULMONARY	0		0	0	0	69.01
69.02	06902	CARDIOPULMONARY	280,101		280,101	0	280,101	69.02
69.03	06903	SLEEP LAB	497,497		497,497	0	497,497	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,602,552		1,602,552	0	1,602,552	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,464,216		6,464,216	0	6,464,216	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	23,354,761		23,354,761	0	23,354,761	73.00
74.00	07400	RENAL DIALYSIS	0		0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	774,804		774,804	0	774,804	88.00
88.01	08801	RURAL HEALTH CLINIC II	983,756		983,756	0	983,756	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
90.00	09000	CLINIC	1,092,756		1,092,756	0	1,092,756	90.00
90.01	09001	IMED	0		0	0	0	90.01
90.02	09002	ONCOLOGY	5,274,012		5,274,012	0	5,274,012	90.02
90.03	09003	OUTPATIENT CENTER	1,292		1,292	0	1,292	90.03
90.04	09004	HBURG URGENT CARE CLINIC	1,973,854		1,973,854	0	1,973,854	90.04
90.05	09005	DIABETES MGMT CLINIC	115,170		115,170	0	115,170	90.05
91.00	09100	EMERGENCY	9,042,901		9,042,901	0	9,042,901	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	3,455,561		3,455,561		3,455,561	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	3,426,952		3,426,952	0	3,426,952	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0		0	0	0	96.00
101.00	10100	HOME HEALTH AGENCY	3,416,465		3,416,465		3,416,465	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0		0		0	116.00
200.00		Subtotal (see instructions)	144,464,943	0	144,464,943	0	144,464,943	200.00
201.00		Less Observation Beds	3,455,561		3,455,561		3,455,561	201.00
202.00		Total (see instructions)	141,009,382	0	141,009,382	0	141,009,382	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0115 | Period: From 07/01/2021 To 06/30/2022 | Worksheet C Part I Date/Time Prepared: 11/29/2022 11:30 am

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	13,614,480		13,614,480			30.00
31.00	03100	INTENSIVE CARE UNIT	10,372,952		10,372,952			31.00
40.00	04000	SUBPROVIDER - IPF	2,339,364		2,339,364			40.00
41.00	04100	SUBPROVIDER - IRF	1,437,174		1,437,174			41.00
43.00	04300	NURSERY	1,683,626		1,683,626			43.00
44.00	04400	SKILLED NURSING FACILITY	1,540,884		1,540,884			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	9,345,074	73,305,187	82,650,261	0.229059	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,466,544	31,437	2,497,981	0.887609	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	906,929	4,292,644	5,199,573	0.297352	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,759,836	75,338,212	86,098,048	0.085708	0.000000	54.00
56.00	05600	RADIOISOTOPE	379,277	12,769,590	13,148,867	0.082624	0.000000	56.00
60.00	06000	LABORATORY	11,771,586	56,585,911	68,357,497	0.172726	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	2,625,334	4,730,486	7,355,820	0.368471	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	6,466,461	7,083,508	13,549,969	0.314392	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	12,843,512	28,105,573	40,949,085	0.159181	0.000000	69.00
69.01	06901	PULMONARY	0	0	0	0.000000	0.000000	69.01
69.02	06902	CARDIOPULMONARY	1,053	1,183,593	1,184,646	0.236443	0.000000	69.02
69.03	06903	SLEEP LAB	0	1,474,855	1,474,855	0.337319	0.000000	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,606,010	8,167,175	10,773,185	0.148754	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,648,818	15,695,138	22,343,956	0.289305	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	31,245,282	86,007,408	117,252,690	0.199183	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0.000000	0.000000	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	781,635	781,635	0.991261	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	965,869	965,869	1.018519	0.000000	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.000000	0.000000	89.00
90.00	09000	CLINIC	81,214	3,782,049	3,863,263	0.282858	0.000000	90.00
90.01	09001	IMED	0	0	0	0.000000	0.000000	90.01
90.02	09002	ONCOLOGY	157,776	22,750,861	22,908,637	0.230219	0.000000	90.02
90.03	09003	OUTPATIENT CENTER	0	0	0	0.000000	0.000000	90.03
90.04	09004	HBURG URGENT CARE CLINIC	7,936	4,453,563	4,461,499	0.442419	0.000000	90.04
90.05	09005	DIABETES MGMT CLINIC	0	147,842	147,842	0.779007	0.000000	90.05
91.00	09100	EMERGENCY	10,627,613	51,546,386	62,173,999	0.145445	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,153,962	7,544,425	8,698,387	0.397265	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,279,371	6,211,529	7,490,900	0.457482	0.000000	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0.000000	0.000000	96.00
101.00	10100	HOME HEALTH AGENCY	0	3,976,571	3,976,571			101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0			116.00
200.00		Subtotal (see instructions)	142,362,068	476,931,447	619,293,515			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	142,362,068	476,931,447	619,293,515			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0115 | Period: From 07/01/2021 To 06/30/2022 | Worksheet C Part I Date/Time Prepared: 11/29/2022 11:30 am

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
40.00	04000	SUBPROVIDER - IPF			40.00
41.00	04100	SUBPROVIDER - IRF			41.00
43.00	04300	NURSERY			43.00
44.00	04400	SKILLED NURSING FACILITY			44.00
		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
56.00	05600	RADIOISOTOPE	0.000000		56.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
69.01	06901	PULMONARY	0.000000		69.01
69.02	06902	CARDIOPULMONARY	0.000000		69.02
69.03	06903	SLEEP LAB	0.000000		69.03
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
74.00	07400	RENAL DIALYSIS	0.000000		74.00
		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
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		89.00
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	IMED	0.000000		90.01
90.02	09002	ONCOLOGY	0.000000		90.02
90.03	09003	OUTPATIENT CENTER	0.000000		90.03
90.04	09004	HBURG URGENT CARE CLINIC	0.000000		90.04
90.05	09005	DIABETES MGMT CLINIC	0.000000		90.05
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000		96.00
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 ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-0115 | Period: From 07/01/2021 To 06/30/2022 | Worksheet D Part I Date/Time Prepared: 11/29/2022 11:30 am

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	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	738,833	0	738,833	12,313	60.00	30.00
31.00	INTENSIVE CARE UNIT	342,317		342,317	4,472	76.55	31.00
40.00	SUBPROVIDER - IPF	253,325	0	253,325	1,337	189.47	40.00
41.00	SUBPROVIDER - IRF	133,221	0	133,221	958	139.06	41.00
43.00	NURSERY	86,604		86,604	1,600	54.13	43.00
44.00	SKILLED NURSING FACILITY	158,606		158,606	4,350	36.46	44.00
200.00	Total (lines 30 through 199)	1,712,906		1,712,906	25,030		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	
		6.00	7.00	
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	3,556	213,360	30.00
31.00	INTENSIVE CARE UNIT	1,641	125,619	31.00
40.00	SUBPROVIDER - IPF	290	54,946	40.00
41.00	SUBPROVIDER - IRF	559	77,735	41.00
43.00	NURSERY	0	0	43.00
44.00	SKILLED NURSING FACILITY	3,138	114,411	44.00
200.00	Total (lines 30 through 199)	9,184	586,071	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-0115 | Period: From 07/01/2021 To 06/30/2022 | Worksheet D Part II Date/Time Prepared: 11/29/2022 11:30 am

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	963,084	82,650,261	0.011653	4,370,128	50,925	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	166,200	2,497,981	0.066534	0	0	52.00
53.00	05300	ANESTHESIOLOGY	5,528	5,199,573	0.001063	342,830	364	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	329,492	86,098,048	0.003827	5,457,706	20,887	54.00
56.00	05600	RADIOISOTOPE	22,881	13,148,867	0.001740	179,254	312	56.00
60.00	06000	LABORATORY	181,163	68,357,497	0.002650	4,623,251	12,252	60.00
65.00	06500	RESPIRATORY THERAPY	62,302	7,355,820	0.008470	1,007,451	8,533	65.00
66.00	06600	PHYSICAL THERAPY	140,440	13,549,969	0.010365	1,477,539	15,315	66.00
69.00	06900	ELECTROCARDIOLOGY	307,014	40,949,085	0.007497	5,807,212	43,537	69.00
69.01	06901	PULMONARY	0	0	0.000000	0	0	69.01
69.02	06902	CARDIOPULMONARY	36,514	1,184,646	0.030823	0	0	69.02
69.03	06903	SLEEP LAB	42,798	1,474,855	0.029018	0	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,740	10,773,185	0.000533	1,297,563	692	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	10,995	22,343,956	0.000492	4,012,332	1,974	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	121,125	117,252,690	0.001033	11,561,112	11,943	73.00
74.00	07400	RENAL DIALYSIS	0	0	0.000000	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	44,232	781,635	0.056589	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	100,084	965,869	0.103621	0	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	09000	CLINIC	128,199	3,863,263	0.033184	40,174	1,333	90.00
90.01	09001	IMED	0	0	0.000000	0	0	90.01
90.02	09002	ONCOLOGY	281,151	22,908,637	0.012273	81,742	1,003	90.02
90.03	09003	OUTPATIENT CENTER	99	0	0.000000	0	0	90.03
90.04	09004	HBURG URGENT CARE CLINIC	128,971	4,461,499	0.028908	2,050	59	90.04
90.05	09005	DIABETES MGMT CLINIC	12,440	147,842	0.084144	0	0	90.05
91.00	09100	EMERGENCY	260,084	62,173,999	0.004183	4,986,344	20,858	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	206,535	8,698,387	0.023744	412,577	9,796	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0.000000	0	0	96.00
200.00		Total (lines 50 through 199)	3,557,071	576,837,564		45,659,265	199,783	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0115 | Period: From 07/01/2021 To 06/30/2022 | Worksheet D Part III Date/Time Prepared: 11/29/2022 11:30 am

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		Cost Center Description	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0		44.00
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	12,313	0.00	3,556	30.00
31.00	03100	INTENSIVE CARE UNIT		0	4,472	0.00	1,641	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	1,337	0.00	290	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	958	0.00	559	41.00
43.00	04300	NURSERY		0	1,600	0.00	0	43.00
44.00	04400	SKILLED NURSING FACILITY		0	4,350	0.00	3,138	44.00
200.00		Total (lines 30 through 199)		0	25,030		9,184	200.00

		Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
			9.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	41.00
43.00	04300	NURSERY	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	44.00
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0115 | Period: From 07/01/2021 To 06/30/2022 | Worksheet D Part IV Date/Time Prepared: 11/29/2022 11:30 am

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		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
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
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	PULMONARY	0	0	0	0	0	69.01
69.02	06902	CARDIOPULMONARY	0	0	0	0	0	69.02
69.03	06903	SLEEP LAB	0	0	0	0	0	69.03
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
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		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
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	IMED	0	0	0	0	0	90.01
90.02	09002	ONCOLOGY	0	0	0	0	0	90.02
90.03	09003	OUTPATIENT CENTER	0	0	0	0	0	90.03
90.04	09004	HBURG URGENT CARE CLINIC	0	0	0	0	0	90.04
90.05	09005	DIABETES MGMT CLINIC	0	0	0	0	0	90.05
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
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: 15-0115 | Period: From 07/01/2021 To 06/30/2022 | Worksheet D Part IV Date/Time Prepared: 11/29/2022 11:30 am

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		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	82,650,261	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	2,497,981	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	5,199,573	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	86,098,048	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	13,148,867	0.000000	56.00
60.00	06000	LABORATORY	0	0	0	68,357,497	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	7,355,820	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	13,549,969	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	40,949,085	0.000000	69.00
69.01	06901	PULMONARY	0	0	0	0	0.000000	69.01
69.02	06902	CARDIOPULMONARY	0	0	0	1,184,646	0.000000	69.02
69.03	06903	SLEEP LAB	0	0	0	1,474,855	0.000000	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	10,773,185	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	22,343,956	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	117,252,690	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0.000000	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	781,635	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	965,869	0.000000	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0.000000	89.00
90.00	09000	CLINIC	0	0	0	3,863,263	0.000000	90.00
90.01	09001	IMED	0	0	0	0	0.000000	90.01
90.02	09002	ONCOLOGY	0	0	0	22,908,637	0.000000	90.02
90.03	09003	OUTPATIENT CENTER	0	0	0	0	0.000000	90.03
90.04	09004	HBURG URGENT CARE CLINIC	0	0	0	4,461,499	0.000000	90.04
90.05	09005	DIABETES MGMT CLINIC	0	0	0	147,842	0.000000	90.05
91.00	09100	EMERGENCY	0	0	0	62,173,999	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	8,698,387	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0.000000	96.00
200.00		Total (lines 50 through 199)	0	0	0	576,837,564		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0115 | Period: From 07/01/2021 To 06/30/2022 | Worksheet D Part IV Date/Time Prepared: 11/29/2022 11:30 am

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		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	4,370,128	0	19,144,124	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	342,830	0	1,375,193	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	5,457,706	0	22,176,617	0	54.00
56.00	05600	RADIOISOTOPE	0.000000	179,254	0	5,626,957	0	56.00
60.00	06000	LABORATORY	0.000000	4,623,251	0	6,897,945	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	1,007,451	0	1,008,206	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	1,477,539	0	195,735	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	5,807,212	0	11,923,755	0	69.00
69.01	06901	PULMONARY	0.000000	0	0	0	0	69.01
69.02	06902	CARDIOPULMONARY	0.000000	0	0	652,960	0	69.02
69.03	06903	SLEEP LAB	0.000000	0	0	417,510	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	1,297,563	0	2,345,303	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	4,012,332	0	6,448,026	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	11,561,112	0	37,553,886	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
		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
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	0	0	89.00
90.00	09000	CLINIC	0.000000	40,174	0	1,211,377	0	90.00
90.01	09001	IMED	0.000000	0	0	0	0	90.01
90.02	09002	ONCOLOGY	0.000000	81,742	0	9,491,185	0	90.02
90.03	09003	OUTPATIENT CENTER	0.000000	0	0	0	0	90.03
90.04	09004	HBURG URGENT CARE CLINIC	0.000000	2,050	0	362,129	0	90.04
90.05	09005	DIABETES MGMT CLINIC	0.000000	0	0	0	0	90.05
91.00	09100	EMERGENCY	0.000000	4,986,344	0	11,820,138	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	412,577	0	997,533	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	0	0	96.00
200.00		Total (lines 50 through 199)		45,659,265	0	139,648,579	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0115 | Period: From 07/01/2021 To 06/30/2022 | Worksheet D Part V Date/Time Prepared: 11/29/2022 11:30 am

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		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	0.229059	19,144,124	0	0	4,385,134	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.887609	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.297352	1,375,193	0	0	408,916	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.085708	22,176,617	0	0	1,900,713	54.00
56.00	05600	RADIOISOTOPE	0.082624	5,626,957	0	0	464,922	56.00
60.00	06000	LABORATORY	0.172726	6,897,945	0	427	1,191,454	60.00
65.00	06500	RESPIRATORY THERAPY	0.368471	1,008,206	0	0	371,495	65.00
66.00	06600	PHYSICAL THERAPY	0.314392	195,735	0	0	61,538	66.00
69.00	06900	ELECTROCARDIOLOGY	0.159181	11,923,755	0	0	1,898,035	69.00
69.01	06901	PULMONARY	0.000000	0	0	0	0	69.01
69.02	06902	CARDIOPULMONARY	0.236443	652,960	0	0	154,388	69.02
69.03	06903	SLEEP LAB	0.337319	417,510	0	0	140,834	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.148754	2,345,303	0	0	348,873	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.289305	6,448,026	0	0	1,865,446	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.199183	37,553,886	0	38,462	7,480,096	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC						88.00
88.01	08801	RURAL HEALTH CLINIC II						88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER						89.00
90.00	09000	CLINIC	0.282858	1,211,377	0	0	342,648	90.00
90.01	09001	IMED	0.000000	0	0	0	0	90.01
90.02	09002	ONCOLOGY	0.230219	9,491,185	0	0	2,185,051	90.02
90.03	09003	OUTPATIENT CENTER	0.000000	0	0	0	0	90.03
90.04	09004	HBURG URGENT CARE CLINIC	0.442419	362,129	0	0	160,213	90.04
90.05	09005	DIABETES MGMT CLINIC	0.779007	0	0	0	0	90.05
91.00	09100	EMERGENCY	0.145445	11,820,138	0	0	1,719,180	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.397265	997,533	0	0	396,285	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.457482		0			95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	0	0	96.00
200.00		Subtotal (see instructions)		139,648,579	0	38,889	25,475,221	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		139,648,579	0	38,889	25,475,221	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0115 | Period: From 07/01/2021 To 06/30/2022 | Worksheet D Part V Date/Time Prepared: 11/29/2022 11:30 am

Title XVIII | Hospital | PPS

		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	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
56.00	05600	RADIOISOTOPE	0	0		56.00
60.00	06000	LABORATORY	0	74		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
69.01	06901	PULMONARY	0	0		69.01
69.02	06902	CARDIOPULMONARY	0	0		69.02
69.03	06903	SLEEP LAB	0	0		69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	7,661		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC				88.00
88.01	08801	RURAL HEALTH CLINIC II				88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER				89.00
90.00	09000	CLINIC	0	0		90.00
90.01	09001	IMED	0	0		90.01
90.02	09002	ONCOLOGY	0	0		90.02
90.03	09003	OUTPATIENT CENTER	0	0		90.03
90.04	09004	HBURG URGENT CARE CLINIC	0	0		90.04
90.05	09005	DIABETES MGMT CLINIC	0	0		90.05
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0		96.00
200.00		Subtotal (see instructions)	0	7,735		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	7,735		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 15-0115 | Component CCN: 15-S115 | Period: From 07/01/2021 To 06/30/2022 | Worksheet D Part II | Date/Time Prepared: 11/29/2022 11:30 am

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	963,084	82,650,261	0.011653	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	166,200	2,497,981	0.066534	0	0	52.00
53.00	05300	ANESTHESIOLOGY	5,528	5,199,573	0.001063	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	329,492	86,098,048	0.003827	26,053	100	54.00
56.00	05600	RADIOISOTOPE	22,881	13,148,867	0.001740	0	0	56.00
60.00	06000	LABORATORY	181,163	68,357,497	0.002650	77,640	206	60.00
65.00	06500	RESPIRATORY THERAPY	62,302	7,355,820	0.008470	367	3	65.00
66.00	06600	PHYSICAL THERAPY	140,440	13,549,969	0.010365	1,136	12	66.00
69.00	06900	ELECTROCARDIOLOGY	307,014	40,949,085	0.007497	3,885	29	69.00
69.01	06901	PULMONARY	0	0	0.000000	0	0	69.01
69.02	06902	CARDIOPULMONARY	36,514	1,184,646	0.030823	0	0	69.02
69.03	06903	SLEEP LAB	42,798	1,474,855	0.029018	0	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,740	10,773,185	0.000533	19	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	10,995	22,343,956	0.000492	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	121,125	117,252,690	0.001033	55,442	57	73.00
74.00	07400	RENAL DIALYSIS	0	0	0.000000	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	44,232	781,635	0.056589	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	100,084	965,869	0.103621	0	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	09000	CLINIC	128,199	3,863,263	0.033184	0	0	90.00
90.01	09001	IMED	0	0	0.000000	0	0	90.01
90.02	09002	ONCOLOGY	281,151	22,908,637	0.012273	0	0	90.02
90.03	09003	OUTPATIENT CENTER	99	0	0.000000	0	0	90.03
90.04	09004	HBURG URGENT CARE CLINIC	128,971	4,461,499	0.028908	0	0	90.04
90.05	09005	DIABETES MGMT CLINIC	12,440	147,842	0.084144	0	0	90.05
91.00	09100	EMERGENCY	260,084	62,173,999	0.004183	87,513	366	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	8,698,387	0.000000	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0.000000	0	0	96.00
200.00		Total (lines 50 through 199)	3,350,536	576,837,564		252,055	773	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0115 | Component CCN: 15-S115 | Period: From 07/01/2021 To 06/30/2022 | Worksheet D Part IV Date/Time Prepared: 11/29/2022 11:30 am

Title XVIII | Subprovider - IPF | PPS

		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
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	PULMONARY	0	0	0	0	0	69.01
69.02	06902	CARDIOPULMONARY	0	0	0	0	0	69.02
69.03	06903	SLEEP LAB	0	0	0	0	0	69.03
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
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		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
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	IMED	0	0	0	0	0	90.01
90.02	09002	ONCOLOGY	0	0	0	0	0	90.02
90.03	09003	OUTPATIENT CENTER	0	0	0	0	0	90.03
90.04	09004	HBURG URGENT CARE CLINIC	0	0	0	0	0	90.04
90.05	09005	DIABETES MGMT CLINIC	0	0	0	0	0	90.05
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
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: 15-0115 | Component CCN: 15-S115 | Period: From 07/01/2021 To 06/30/2022 | Worksheet D Part IV | Date/Time Prepared: 11/29/2022 11:30 am

Title XVIII | Subprovider - IPF | PPS

		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	82,650,261	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	2,497,981	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	5,199,573	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	86,098,048	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	13,148,867	0.000000	56.00
60.00	06000	LABORATORY	0	0	0	68,357,497	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	7,355,820	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	13,549,969	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	40,949,085	0.000000	69.00
69.01	06901	PULMONARY	0	0	0	0	0.000000	69.01
69.02	06902	CARDIOPULMONARY	0	0	0	1,184,646	0.000000	69.02
69.03	06903	SLEEP LAB	0	0	0	1,474,855	0.000000	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	10,773,185	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	22,343,956	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	117,252,690	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0.000000	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	781,635	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	965,869	0.000000	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0.000000	89.00
90.00	09000	CLINIC	0	0	0	3,863,263	0.000000	90.00
90.01	09001	IMED	0	0	0	0	0.000000	90.01
90.02	09002	ONCOLOGY	0	0	0	22,908,637	0.000000	90.02
90.03	09003	OUTPATIENT CENTER	0	0	0	0	0.000000	90.03
90.04	09004	HBURG URGENT CARE CLINIC	0	0	0	4,461,499	0.000000	90.04
90.05	09005	DIABETES MGMT CLINIC	0	0	0	147,842	0.000000	90.05
91.00	09100	EMERGENCY	0	0	0	62,173,999	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	8,698,387	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0.000000	96.00
200.00		Total (lines 50 through 199)	0	0	0	576,837,564		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0115 | Component CCN: 15-S115 | Period: From 07/01/2021 To 06/30/2022 | Worksheet D Part IV Date/Time Prepared: 11/29/2022 11:30 am

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	26,053	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
60.00	06000	LABORATORY	0.000000	77,640	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	367	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	1,136	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	3,885	0	0	0	69.00
69.01	06901	PULMONARY	0.000000	0	0	0	0	69.01
69.02	06902	CARDIOPULMONARY	0.000000	0	0	0	0	69.02
69.03	06903	SLEEP LAB	0.000000	0	0	0	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	19	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	55,442	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
		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
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	0	0	89.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	IMED	0.000000	0	0	0	0	90.01
90.02	09002	ONCOLOGY	0.000000	0	0	0	0	90.02
90.03	09003	OUTPATIENT CENTER	0.000000	0	0	0	0	90.03
90.04	09004	HBURG URGENT CARE CLINIC	0.000000	0	0	0	0	90.04
90.05	09005	DIABETES MGMT CLINIC	0.000000	0	0	0	0	90.05
91.00	09100	EMERGENCY	0.000000	87,513	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	0	0	96.00
200.00		Total (lines 50 through 199)		252,055	0	0	0	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 15-0115 | Component CCN: 15-T115 | Period: From 07/01/2021 To 06/30/2022 | Worksheet D Part II Date/Time Prepared: 11/29/2022 11:30 am

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	963,084	82,650,261	0.011653	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	166,200	2,497,981	0.066534	0	0	52.00
53.00	05300	ANESTHESIOLOGY	5,528	5,199,573	0.001063	319	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	329,492	86,098,048	0.003827	11,378	44	54.00
56.00	05600	RADIOISOTOPE	22,881	13,148,867	0.001740	0	0	56.00
60.00	06000	LABORATORY	181,163	68,357,497	0.002650	44,417	118	60.00
65.00	06500	RESPIRATORY THERAPY	62,302	7,355,820	0.008470	5,601	47	65.00
66.00	06600	PHYSICAL THERAPY	140,440	13,549,969	0.010365	833,268	8,637	66.00
69.00	06900	ELECTROCARDIOLOGY	307,014	40,949,085	0.007497	12,122	91	69.00
69.01	06901	PULMONARY	0	0	0.000000	0	0	69.01
69.02	06902	CARDIOPULMONARY	36,514	1,184,646	0.030823	0	0	69.02
69.03	06903	SLEEP LAB	42,798	1,474,855	0.029018	0	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,740	10,773,185	0.000533	1,663	1	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	10,995	22,343,956	0.000492	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	121,125	117,252,690	0.001033	155,552	161	73.00
74.00	07400	RENAL DIALYSIS	0	0	0.000000	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	44,232	781,635	0.056589	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	100,084	965,869	0.103621	0	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	09000	CLINIC	128,199	3,863,263	0.033184	950	32	90.00
90.01	09001	IMED	0	0	0.000000	0	0	90.01
90.02	09002	ONCOLOGY	281,151	22,908,637	0.012273	0	0	90.02
90.03	09003	OUTPATIENT CENTER	99	0	0.000000	0	0	90.03
90.04	09004	HBURG URGENT CARE CLINIC	128,971	4,461,499	0.028908	0	0	90.04
90.05	09005	DIABETES MGMT CLINIC	12,440	147,842	0.084144	0	0	90.05
91.00	09100	EMERGENCY	260,084	62,173,999	0.004183	180	1	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	8,698,387	0.000000	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0.000000	0	0	96.00
200.00		Total (lines 50 through 199)	3,350,536	576,837,564		1,065,450	9,132	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0115 | Component CCN: 15-T115 | Period: From 07/01/2021 To 06/30/2022 | Worksheet D Part IV Date/Time Prepared: 11/29/2022 11:30 am

Title XVIII | Subprovider - IRF | PPS

		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
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	PULMONARY	0	0	0	0	0	69.01
69.02	06902	CARDIOPULMONARY	0	0	0	0	0	69.02
69.03	06903	SLEEP LAB	0	0	0	0	0	69.03
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
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		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
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	IMED	0	0	0	0	0	90.01
90.02	09002	ONCOLOGY	0	0	0	0	0	90.02
90.03	09003	OUTPATIENT CENTER	0	0	0	0	0	90.03
90.04	09004	HBURG URGENT CARE CLINIC	0	0	0	0	0	90.04
90.05	09005	DIABETES MGMT CLINIC	0	0	0	0	0	90.05
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
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: 15-0115 | Component CCN: 15-T115 | Period: From 07/01/2021 To 06/30/2022 | Worksheet D Part IV Date/Time Prepared: 11/29/2022 11:30 am

Title XVIII | Subprovider - IRF | PPS

		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	82,650,261	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	2,497,981	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	5,199,573	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	86,098,048	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	13,148,867	0.000000	56.00
60.00	06000	LABORATORY	0	0	0	68,357,497	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	7,355,820	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	13,549,969	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	40,949,085	0.000000	69.00
69.01	06901	PULMONARY	0	0	0	0	0.000000	69.01
69.02	06902	CARDIOPULMONARY	0	0	0	1,184,646	0.000000	69.02
69.03	06903	SLEEP LAB	0	0	0	1,474,855	0.000000	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	10,773,185	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	22,343,956	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	117,252,690	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0.000000	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	781,635	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	965,869	0.000000	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0.000000	89.00
90.00	09000	CLINIC	0	0	0	3,863,263	0.000000	90.00
90.01	09001	IMED	0	0	0	0	0.000000	90.01
90.02	09002	ONCOLOGY	0	0	0	22,908,637	0.000000	90.02
90.03	09003	OUTPATIENT CENTER	0	0	0	0	0.000000	90.03
90.04	09004	HBURG URGENT CARE CLINIC	0	0	0	4,461,499	0.000000	90.04
90.05	09005	DIABETES MGMT CLINIC	0	0	0	147,842	0.000000	90.05
91.00	09100	EMERGENCY	0	0	0	62,173,999	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	8,698,387	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0.000000	96.00
200.00		Total (lines 50 through 199)	0	0	0	576,837,564		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0115 | Component CCN: 15-T115 | Period: From 07/01/2021 To 06/30/2022 | Worksheet D Part IV Date/Time Prepared: 11/29/2022 11:30 am

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	319	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	11,378	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
60.00	06000	LABORATORY	0.000000	44,417	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	5,601	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	833,268	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	12,122	0	0	0	69.00
69.01	06901	PULMONARY	0.000000	0	0	0	0	69.01
69.02	06902	CARDIOPULMONARY	0.000000	0	0	0	0	69.02
69.03	06903	SLEEP LAB	0.000000	0	0	0	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	1,663	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	155,552	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
		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
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	0	0	89.00
90.00	09000	CLINIC	0.000000	950	0	0	0	90.00
90.01	09001	IMED	0.000000	0	0	0	0	90.01
90.02	09002	ONCOLOGY	0.000000	0	0	0	0	90.02
90.03	09003	OUTPATIENT CENTER	0.000000	0	0	0	0	90.03
90.04	09004	HBURG URGENT CARE CLINIC	0.000000	0	0	0	0	90.04
90.05	09005	DIABETES MGMT CLINIC	0.000000	0	0	0	0	90.05
91.00	09100	EMERGENCY	0.000000	180	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	0	0	96.00
200.00		Total (lines 50 through 199)		1,065,450	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0115 | Period: From 07/01/2021 To 06/30/2022 | Worksheet D Part V Date/Time Prepared: 11/29/2022 11:30 am

Title XIX | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.229059	0	657,399	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.887609	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.297352	0	42,432	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.085708	0	960,695	0	0	54.00
56.00	05600	RADIOISOTOPE	0.082624	0	79,877	0	0	56.00
60.00	06000	LABORATORY	0.172726	0	790,754	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.368471	0	25,283	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.314392	0	95,675	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.159181	0	139,747	0	0	69.00
69.01	06901	PULMONARY	0.000000	0	0	0	0	69.01
69.02	06902	CARDIOPULMONARY	0.236443	0	0	0	0	69.02
69.03	06903	SLEEP LAB	0.337319	0	27,765	0	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.148754	0	70,208	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.289305	0	109,713	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.199183	0	1,428,393	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC						88.00
88.01	08801	RURAL HEALTH CLINIC II						88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER						89.00
90.00	09000	CLINIC	0.282858	0	87,455	0	0	90.00
90.01	09001	IMED	0.000000	0	0	0	0	90.01
90.02	09002	ONCOLOGY	0.230219	0	216,891	0	0	90.02
90.03	09003	OUTPATIENT CENTER	0.000000	0	0	0	0	90.03
90.04	09004	HBURG URGENT CARE CLINIC	0.442419	0	57,433	0	0	90.04
90.05	09005	DIABETES MGMT CLINIC	0.779007	0	1,852	0	0	90.05
91.00	09100	EMERGENCY	0.145445	0	1,297,159	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.397265	0	68,691	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.457482	0	291,235			95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	0	0	96.00
200.00		Subtotal (see instructions)		0	6,448,657	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	6,448,657	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0115 | Period: From 07/01/2021 To 06/30/2022 | Worksheet D Part V Date/Time Prepared: 11/29/2022 11:30 am

Title XIX | 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	150,583	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	12,617	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	82,339	0		54.00
56.00	05600	RADIOISOTOPE	6,600	0		56.00
60.00	06000	LABORATORY	136,584	0		60.00
65.00	06500	RESPIRATORY THERAPY	9,316	0		65.00
66.00	06600	PHYSICAL THERAPY	30,079	0		66.00
69.00	06900	ELECTROCARDIOLOGY	22,245	0		69.00
69.01	06901	PULMONARY	0	0		69.01
69.02	06902	CARDIOPULMONARY	0	0		69.02
69.03	06903	SLEEP LAB	9,366	0		69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	10,444	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	31,741	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	284,512	0		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC				88.00
88.01	08801	RURAL HEALTH CLINIC II				88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER				89.00
90.00	09000	CLINIC	24,737	0		90.00
90.01	09001	IMED	0	0		90.01
90.02	09002	ONCOLOGY	49,932	0		90.02
90.03	09003	OUTPATIENT CENTER	0	0		90.03
90.04	09004	HBURG URGENT CARE CLINIC	25,409	0		90.04
90.05	09005	DIABETES MGMT CLINIC	1,443	0		90.05
91.00	09100	EMERGENCY	188,665	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	27,289	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	133,235			95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0		96.00
200.00		Subtotal (see instructions)	1,237,136	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	1,237,136	0		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0115 | Period: From 07/01/2021 To 06/30/2022 | Worksheet D-1 | Date/Time Prepared: 11/29/2022 11:30 am

Title XVIII | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	12,313	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	12,313	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)	8,871	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	3,556	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	12,361,547	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	12,361,547	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)	12,361,547	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,003.94	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	3,570,011	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	3,570,011	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0115 | Period: From 07/01/2021 To 06/30/2022 | Worksheet D-1 | Date/Time Prepared: 11/29/2022 11:30 am

Title XVIII | Hospital | PPS

	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	6,277,151	4,472	1,403.66	1,641	2,303,406	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)	8,721,048	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	14,594,465	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)	338,979	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	199,783	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	538,762	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	14,055,703	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)	3,442	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,003.94	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	3,455,561	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0115 | Period: From 07/01/2021 To 06/30/2022 | Worksheet D-1 | Date/Time Prepared: 11/29/2022 11:30 am

Title XVIII | Hospital | PPS

	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	738,833	12,361,547	0.059769	3,455,561	206,535	90.00
91.00	Nursing Program cost	0	12,361,547	0.000000	3,455,561	0	91.00
92.00	Allied health cost	0	12,361,547	0.000000	3,455,561	0	92.00
93.00	All other Medical Education	0	12,361,547	0.000000	3,455,561	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0115 Component CCN: 15-S115	Period: From 07/01/2021 To 06/30/2022	Worksheet D-1 Date/Time Prepared: 11/29/2022 11:30 am
	Title XVIII	Subprovider - IPF	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	1,337	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,337	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)	1,337	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	290	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,349,077	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,349,077	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)	2,349,077	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,756.98	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	509,524	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)	509,524	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0115 | Component CCN: 15-S115 | Period: From 07/01/2021 To 06/30/2022 | Worksheet D-1 | Date/Time Prepared: 11/29/2022 11:30 am

Title XVIII | Subprovider - IPF | PPS

	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)	40,527	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	550,051	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)	54,946	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	773	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	55,719	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	494,332	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)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0115 Component CCN: 15-S115	Period: From 07/01/2021 To 06/30/2022	Worksheet D-1 Date/Time Prepared: 11/29/2022 11:30 am
	Title XVIII	Subprovider - IPF	PPS

	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	253,325	2,349,077	0.107840	0	0	90.00
91.00	Nursing Program cost	0	2,349,077	0.000000	0	0	91.00
92.00	Allied health cost	0	2,349,077	0.000000	0	0	92.00
93.00	All other Medical Education	0	2,349,077	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0115 Component CCN: 15-T115	Period: From 07/01/2021 To 06/30/2022	Worksheet D-1 Date/Time Prepared: 11/29/2022 11:30 am
	Title XVIII	Subprovider - IRF	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	958	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	958	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)	958	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	559	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	1,224,932	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	1,224,932	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)	1,224,932	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,278.63	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	714,754	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)	714,754	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0115 | Component CCN: 15-T115 | Period: From 07/01/2021 To 06/30/2022 | Worksheet D-1 | Date/Time Prepared: 11/29/2022 11:30 am

Title XVIII | Subprovider - IRF | PPS

	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)	306,234	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	1,020,988	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)	77,735	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	9,132	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	86,867	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	934,121	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)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0115 Component CCN: 15-T115	Period: From 07/01/2021 To 06/30/2022	Worksheet D-1 Date/Time Prepared: 11/29/2022 11:30 am
	Title XVIII	Subprovider - IRF	PPS

	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	133,221	1,224,932	0.108758	0	0	90.00
91.00	Nursing Program cost	0	1,224,932	0.000000	0	0	91.00
92.00	Allied health cost	0	1,224,932	0.000000	0	0	92.00
93.00	All other Medical Education	0	1,224,932	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0115 Component CCN: 15-5305	Period: From 07/01/2021 To 06/30/2022	Worksheet D-1 Date/Time Prepared: 11/29/2022 11:30 am
	Title XVIII	Skilled Nursing Facility	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	4,350	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	4,350	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)	4,350	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	3,138	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,833,439	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,833,439	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)	2,833,439	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)		38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0115 | Period: From 07/01/2021 To 06/30/2022 | Worksheet D-1

Component CCN: 15-5305 | Date/Time Prepared: 11/29/2022 11:30 am

Title XVIII | Skilled Nursing Facility | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						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)		48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)		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)		50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)		51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)		52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)		53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges		54.00
55.00	Target amount per discharge		55.00
56.00	Target amount (line 54 x line 55)		56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)		57.00
58.00	Bonus payment (see instructions)		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		59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket		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)		61.00
62.00	Relief payment (see instructions)		62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)		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)		64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)		65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)		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)		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)		68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)		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)	2,833,439	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	651.37	71.00
72.00	Program routine service cost (line 9 x line 71)	2,043,999	72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)	0	73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)	2,043,999	74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)	0	75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)	0.00	76.00
77.00	Program capital-related costs (line 9 x line 76)	0	77.00
78.00	Inpatient routine service cost (line 74 minus line 77)	0	78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)	0	79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)	0	80.00
81.00	Inpatient routine service cost per diem limitation	0.00	81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)	0	82.00
83.00	Reasonable inpatient routine service costs (see instructions)	2,043,999	83.00
84.00	Program inpatient ancillary services (see instructions)	940,824	84.00
85.00	Utilization review - physician compensation (see instructions)	0	85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)	2,984,823	86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0115 Component CCN: 15-5305	Period: From 07/01/2021 To 06/30/2022	Worksheet D-1 Date/Time Prepared: 11/29/2022 11:30 am
	Title XVIII	Skilled Nursing Facility	PPS

	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	0	0	0.000000	0	0	90.00
91.00	Nursing Program cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0115 | Period: From 07/01/2021 To 06/30/2022 | Worksheet D-1 | Date/Time Prepared: 11/29/2022 11:30 am

Title XIX | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	12,313	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	12,313	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)	8,871	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	103	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)	1,600	15.00
16.00	Nursery days (title V or XIX only)	55	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	12,361,547	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	12,361,547	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)	12,361,547	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,003.94	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	103,406	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)	103,406	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0115 | Period: From 07/01/2021 To 06/30/2022 | Worksheet D-1 | Date/Time Prepared: 11/29/2022 11:30 am

Title XIX | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	1,205,523	1,600	753.45	55	41,440	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	6,277,151	4,472	1,403.66	129	181,072	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)	355,327	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	681,245	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)	3,442	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,003.94	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	3,455,561	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0115 | Period: From 07/01/2021 To 06/30/2022 | Worksheet D-1 | Date/Time Prepared: 11/29/2022 11:30 am

Title XIX | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	738,833	12,361,547	0.059769	3,455,561	206,535	90.00
91.00	Nursing Program cost	0	12,361,547	0.000000	3,455,561	0	91.00
92.00	Allied health cost	0	12,361,547	0.000000	3,455,561	0	92.00
93.00	All other Medical Education	0	12,361,547	0.000000	3,455,561	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0115 Component CCN: 15-S115	Period: From 07/01/2021 To 06/30/2022	Worksheet D-1 Date/Time Prepared: 11/29/2022 11:30 am
	Title XIX	Subprovider - IPF	Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	1,337	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,337	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)	1,337	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	531	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)	1,600	15.00
16.00	Nursery days (title V or XIX only)	55	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,349,077	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,349,077	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)	2,349,077	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,756.98	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	932,956	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)	932,956	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0115 | Component CCN: 15-S115 | Period: From 07/01/2021 To 06/30/2022 | Worksheet D-1 | Date/Time Prepared: 11/29/2022 11:30 am

Title XIX | Subprovider - IPF | 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)	0	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	932,956	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)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0115
Component CCN: 15-S115

Period:
From 07/01/2021
To 06/30/2022

Worksheet D-1

Date/Time Prepared:
11/29/2022 11:30 am

Title XIX

Subprovider - IPF

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	253,325	2,349,077	0.107840	0	0	90.00
91.00	Nursing Program cost	0	2,349,077	0.000000	0	0	91.00
92.00	Allied health cost	0	2,349,077	0.000000	0	0	92.00
93.00	All other Medical Education	0	2,349,077	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0115 | Period: From 07/01/2021 To 06/30/2022 | Worksheet D-3 | Date/Time Prepared: 11/29/2022 11:30 am

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		5,125,524		30.00
31.00	03100	INTENSIVE CARE UNIT		4,427,929		31.00
40.00	04000	SUBPROVIDER - IPF		40,710		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.229059	4,370,128	1,001,017	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.887609	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.297352	342,830	101,941	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.085708	5,457,706	467,769	54.00
56.00	05600	RADIOISOTOPE	0.082624	179,254	14,811	56.00
60.00	06000	LABORATORY	0.172726	4,623,251	798,556	60.00
65.00	06500	RESPIRATORY THERAPY	0.368471	1,007,451	371,216	65.00
66.00	06600	PHYSICAL THERAPY	0.314392	1,477,539	464,526	66.00
69.00	06900	ELECTROCARDIOLOGY	0.159181	5,807,212	924,398	69.00
69.01	06901	PULMONARY	0.000000	0	0	69.01
69.02	06902	CARDIOPULMONARY	0.236443	0	0	69.02
69.03	06903	SLEEP LAB	0.337319	0	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.148754	1,297,563	193,018	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.289305	4,012,332	1,160,788	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.199183	11,561,112	2,302,777	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	74.00
		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
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
90.00	09000	CLINIC	0.282858	40,174	11,364	90.00
90.01	09001	IMED	0.000000	0	0	90.01
90.02	09002	ONCOLOGY	0.230219	81,742	18,819	90.02
90.03	09003	OUTPATIENT CENTER	0.000000	0	0	90.03
90.04	09004	HBURG URGENT CARE CLINIC	0.442419	2,050	907	90.04
90.05	09005	DIABETES MGMT CLINIC	0.779007	0	0	90.05
91.00	09100	EMERGENCY	0.145445	4,986,344	725,239	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.397265	412,577	163,902	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	96.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		45,659,265	8,721,048	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)		45,659,265		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0115 | Component CCN: 15-S115 | Period: From 07/01/2021 To 06/30/2022 | Worksheet D-3 | Date/Time Prepared: 11/29/2022 11:30 am

Title XVIII | Subprovider - IPF | 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
40.00	04000	SUBPROVIDER - IPF		512,820		40.00
41.00	04100	SUBPROVIDER - IRF				41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.229059	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.887609	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.297352	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.085708	26,053	2,233	54.00
56.00	05600	RADIOISOTOPE	0.082624	0	0	56.00
60.00	06000	LABORATORY	0.172726	77,640	13,410	60.00
65.00	06500	RESPIRATORY THERAPY	0.368471	367	135	65.00
66.00	06600	PHYSICAL THERAPY	0.314392	1,136	357	66.00
69.00	06900	ELECTROCARDIOLOGY	0.159181	3,885	618	69.00
69.01	06901	PULMONARY	0.000000	0	0	69.01
69.02	06902	CARDIOPULMONARY	0.236443	0	0	69.02
69.03	06903	SLEEP LAB	0.337319	0	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.148754	19	3	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.289305	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.199183	55,442	11,043	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	74.00
		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
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
90.00	09000	CLINIC	0.282858	0	0	90.00
90.01	09001	IMED	0.000000	0	0	90.01
90.02	09002	ONCOLOGY	0.230219	0	0	90.02
90.03	09003	OUTPATIENT CENTER	0.000000	0	0	90.03
90.04	09004	HBURG URGENT CARE CLINIC	0.442419	0	0	90.04
90.05	09005	DIABETES MGMT CLINIC	0.779007	0	0	90.05
91.00	09100	EMERGENCY	0.145445	87,513	12,728	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.397265	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	96.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		252,055	40,527	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)		252,055		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0115 | Component CCN: 15-T115 | Period: From 07/01/2021 To 06/30/2022 | Worksheet D-3 | Date/Time Prepared: 11/29/2022 11:30 am

Title XVIII | Subprovider - IRF | 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
40.00	04000	SUBPROVIDER - IPF				40.00
41.00	04100	SUBPROVIDER - IRF		818,169		41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.229059	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.887609	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.297352	319	95	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.085708	11,378	975	54.00
56.00	05600	RADIOISOTOPE	0.082624	0	0	56.00
60.00	06000	LABORATORY	0.172726	44,417	7,672	60.00
65.00	06500	RESPIRATORY THERAPY	0.368471	5,601	2,064	65.00
66.00	06600	PHYSICAL THERAPY	0.314392	833,268	261,973	66.00
69.00	06900	ELECTROCARDIOLOGY	0.159181	12,122	1,930	69.00
69.01	06901	PULMONARY	0.000000	0	0	69.01
69.02	06902	CARDIOPULMONARY	0.236443	0	0	69.02
69.03	06903	SLEEP LAB	0.337319	0	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.148754	1,663	247	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.289305	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.199183	155,552	30,983	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	74.00
		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
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
90.00	09000	CLINIC	0.282858	950	269	90.00
90.01	09001	IMED	0.000000	0	0	90.01
90.02	09002	ONCOLOGY	0.230219	0	0	90.02
90.03	09003	OUTPATIENT CENTER	0.000000	0	0	90.03
90.04	09004	HBURG URGENT CARE CLINIC	0.442419	0	0	90.04
90.05	09005	DIABETES MGMT CLINIC	0.779007	0	0	90.05
91.00	09100	EMERGENCY	0.145445	180	26	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.397265	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	96.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,065,450	306,234	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)		1,065,450		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0115 | Component CCN: 15-5305 | Period: From 07/01/2021 To 06/30/2022 | Worksheet D-3 | Date/Time Prepared: 11/29/2022 11:30 am

Title XVIII | Skilled Nursing Facility | 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
40.00	04000	SUBPROVIDER - IPF				40.00
41.00	04100	SUBPROVIDER - IRF				41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.229059	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.887609	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.297352	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.085708	80,805	6,926	54.00
56.00	05600	RADIOISOTOPE	0.082624	0	0	56.00
60.00	06000	LABORATORY	0.172726	395,409	68,297	60.00
65.00	06500	RESPIRATORY THERAPY	0.368471	49,461	18,225	65.00
66.00	06600	PHYSICAL THERAPY	0.314392	1,874,451	589,312	66.00
69.00	06900	ELECTROCARDIOLOGY	0.159181	13,081	2,082	69.00
69.01	06901	PULMONARY	0.000000	0	0	69.01
69.02	06902	CARDIOPULMONARY	0.236443	0	0	69.02
69.03	06903	SLEEP LAB	0.337319	0	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.148754	17,737	2,638	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.289305	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.199183	1,271,320	253,225	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	74.00
		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
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
90.00	09000	CLINIC	0.282858	420	119	90.00
90.01	09001	IMED	0.000000	0	0	90.01
90.02	09002	ONCOLOGY	0.230219	0	0	90.02
90.03	09003	OUTPATIENT CENTER	0.000000	0	0	90.03
90.04	09004	HBURG URGENT CARE CLINIC	0.442419	0	0	90.04
90.05	09005	DIABETES MGMT CLINIC	0.779007	0	0	90.05
91.00	09100	EMERGENCY	0.145445	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.397265	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	96.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		3,702,684	940,824	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		3,702,684		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0115 | Period: From 07/01/2021 To 06/30/2022 | Worksheet D-3 | Date/Time Prepared: 11/29/2022 11:30 am

Title XIX | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		266,001		30.00
31.00	03100	INTENSIVE CARE UNIT		361,555		31.00
40.00	04000	SUBPROVIDER - IPF		75,972		40.00
41.00	04100	SUBPROVIDER - IRF		70,035		41.00
43.00	04300	NURSERY		0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.229059	105,288	24,117	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.887609	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.297352	11,917	3,544	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.085708	161,480	13,840	54.00
56.00	05600	RADIOISOTOPE	0.082624	3,286	272	56.00
60.00	06000	LABORATORY	0.172726	236,452	40,841	60.00
65.00	06500	RESPIRATORY THERAPY	0.368471	105,543	38,890	65.00
66.00	06600	PHYSICAL THERAPY	0.314392	33,732	10,605	66.00
69.00	06900	ELECTROCARDIOLOGY	0.159181	270,605	43,075	69.00
69.01	06901	PULMONARY	0.000000	0	0	69.01
69.02	06902	CARDIOPULMONARY	0.236443	0	0	69.02
69.03	06903	SLEEP LAB	0.337319	0	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.148754	25,299	3,763	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.289305	25,717	7,440	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.199183	666,059	132,668	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.991261	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	1.018519	0	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	89.00
90.00	09000	CLINIC	0.282858	3,646	1,031	90.00
90.01	09001	IMED	0.000000	0	0	90.01
90.02	09002	ONCOLOGY	0.230219	0	0	90.02
90.03	09003	OUTPATIENT CENTER	0.000000	0	0	90.03
90.04	09004	HBURG URGENT CARE CLINIC	0.442419	0	0	90.04
90.05	09005	DIABETES MGMT CLINIC	0.779007	0	0	90.05
91.00	09100	EMERGENCY	0.145445	237,139	34,491	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.397265	1,887	750	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	96.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,888,050	355,327	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)		1,888,050		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0115 | Component CCN: 15-S115 | Period: From 07/01/2021 To 06/30/2022 | Worksheet D-3 | Date/Time Prepared: 11/29/2022 11:30 am

Title XIX | Subprovider - IPF | 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
40.00	04000	SUBPROVIDER - IPF		75,972		40.00
41.00	04100	SUBPROVIDER - IRF				41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.229059	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.887609	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.297352	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.085708	0	0	54.00
56.00	05600	RADIOISOTOPE	0.082624	0	0	56.00
60.00	06000	LABORATORY	0.172726	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.368471	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.314392	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.159181	0	0	69.00
69.01	06901	PULMONARY	0.000000	0	0	69.01
69.02	06902	CARDIOPULMONARY	0.236443	0	0	69.02
69.03	06903	SLEEP LAB	0.337319	0	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.148754	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.289305	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.199183	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.991261	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	1.018519	0	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	89.00
90.00	09000	CLINIC	0.282858	0	0	90.00
90.01	09001	IMED	0.000000	0	0	90.01
90.02	09002	ONCOLOGY	0.230219	0	0	90.02
90.03	09003	OUTPATIENT CENTER	0.000000	0	0	90.03
90.04	09004	HBURG URGENT CARE CLINIC	0.442419	0	0	90.04
90.05	09005	DIABETES MGMT CLINIC	0.779007	0	0	90.05
91.00	09100	EMERGENCY	0.145445	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.397265	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	96.00
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: 15-0115	Period: From 07/01/2021 To 06/30/2022	Worksheet E Part A Date/Time Prepared: 11/29/2022 11:30 am
	Title XVIII	Hospital	PPS

		1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		
1.00	DRG Amounts Other than Outlier Payments	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	8,234,447	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	6,586,836	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)	0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)	0	1.04
2.00	Outlier payments for discharges. (see instructions)		2.00
2.01	Outlier reconciliation amount	0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)	0	2.02
2.03	Outlier payments for discharges occurring prior to October 1 (see instructions)	998	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)	1,789	2.04
3.00	Managed Care Simulated Payments	4,310,004	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	86.57	4.00
	Indirect Medical Education Adjustment		
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)	0.00	5.00
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)	0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.	0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.	0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)	0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)	0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.	0.00	11.00
12.00	Current year allowable FTE (see instructions)	0.00	12.00
13.00	Total allowable FTE count for the prior year.	0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.	0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.	0.00	15.00
16.00	Adjustment for residents in initial years of the program	14.53	16.00
17.00	Adjustment for residents displaced by program or hospital closure	0.00	17.00
18.00	Adjusted rolling average FTE count	14.53	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.167841	19.00
20.00	Prior year resident to bed ratio (see instructions)	0.164274	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.164274	21.00
22.00	IME payment adjustment (see instructions)	1,271,281	22.00
22.01	IME payment adjustment - Managed Care (see instructions)	369,686	22.01
	Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA		
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).	0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)	0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)	0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)	0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)	0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)	0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)	0	28.01
29.00	Total IME payment (sum of lines 22 and 28)	1,271,281	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	369,686	29.01
	Disproportionate Share Adjustment		
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	2.09	30.00
31.00	Percentage of Medicaid patient days (see instructions)	16.17	31.00
32.00	Sum of lines 30 and 31	18.26	32.00
33.00	Allowable disproportionate share percentage (see instructions)	4.62	33.00
34.00	Disproportionate share adjustment (see instructions)	171,186	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0115	Period: From 07/01/2021 To 06/30/2022	Worksheet E Part A Date/Time Prepared: 11/29/2022 11:30 am
	Title XVIII	Hospital	PPS

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	Uncompensated Care Adjustment			
35.00	Total uncompensated care amount (see instructions)	8,290,014,521	7,192,008,710	35.00
35.01	Factor 3 (see instructions)	0.000159904	0.000101243	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	1,325,606	728,139	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	334,126	544,608	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	878,734		36.00
	Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)			
40.00	Total Medicare discharges (see instructions)	0		40.00

		Before 1/1	On/After 1/1	
		1.00	1.01	
41.00	Total ESRD Medicare discharges (see instructions)	0	0	41.00
41.01	Total ESRD Medicare covered and paid discharges (see instructions)	0	0	41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days (see instructions)	0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00	0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00
47.00	Subtotal (see instructions)	17,145,271		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	0		48.00

		Amount	
		1.00	
49.00	Total payment for inpatient operating costs (see instructions)	17,514,957	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	1,228,545	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)	0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).	330,941	52.00
53.00	Nursing and Allied Health Managed Care payment	0	53.00
54.00	Special add-on payments for new technologies	146,066	54.00
54.01	Islet isolation add-on payment	0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)	0	55.00
56.00	Cost of physicians' services in a teaching hospital (see intructions)	0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).	0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)	0	58.00
59.00	Total (sum of amounts on lines 49 through 58)	19,220,509	59.00
60.00	Primary payer payments	16,960	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	19,203,549	61.00
62.00	Deductibles billed to program beneficiaries	1,947,908	62.00
63.00	Coinsurance billed to program beneficiaries	12,704	63.00
64.00	Allowable bad debts (see instructions)	59,664	64.00
65.00	Adjusted reimbursable bad debts (see instructions)	38,782	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	51	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	17,281,719	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)	0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)	0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	70.00
70.50	Rural Community Hospital Demonstration Project (§410A Demonstration) adjustment (see instructions)	0	70.50
70.87	Demonstration payment adjustment amount before sequestration	0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)	0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)	0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)	0	70.91
70.92	Bundled Model 1 discount amount (see instructions)	0	70.92
70.93	HVBP payment adjustment amount (see instructions)	6,919	70.93
70.94	HRR adjustment amount (see instructions)	-6,467	70.94
70.95	Recovery of accelerated depreciation	0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0115	Period: From 07/01/2021 To 06/30/2022	Worksheet E Part A Date/Time Prepared: 11/29/2022 11:30 am
	Title XVIII	Hospital	PPS

		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	2021	115,709	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	2022	358,818	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		180,760	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		17,575,938	71.00
71.01	Sequestration adjustment (see instructions)		43,940	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
71.03	Sequestration adjustment-PARHM pass-throughs			71.03
72.00	Interim payments		16,324,714	72.00
72.01	Interim payments-PARHM			72.01
73.00	Tentative settlement (for contractor use only)		0	73.00
73.01	Tentative settlement-PARHM (for contractor use only)			73.01
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		1,207,284	74.00
74.01	Balance due provider/program-PARHM (see instructions)			74.01
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		426,963	75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00

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

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 15-0115 | Period: From 07/01/2021 To 06/30/2022 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 11/29/2022 11:30 am

Title XVIII | Hospital | PPS

		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	8,234,447	0	8,234,447		8,234,447	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	6,586,836	0		6,586,836	6,586,836	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00						2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	998	0	0		998	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	1,789	0		1,789	1,789	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	4,310,004	0	0	4,310,004	4,310,004	4.00
	Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.164274	0.164274	0.164274	0.164274		5.00
6.00	IME payment adjustment (see instructions)	22.00	1,271,281	0	706,302	564,979	1,271,281	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	369,686	0	0	369,686	369,686	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	1,271,281	0	706,302	564,979	1,271,281	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	369,686	0	0	369,686	369,686	9.01
	Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0462	0.0462	0.0462	0.0462		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	171,186	0	95,108	76,078	171,186	11.00
11.01	Uncompensated care payments	36.00	878,734	0	334,126	544,608	878,734	11.01
	Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	17,145,271	0	9,369,983	7,775,288	17,145,271	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	17,514,957	0	9,369,983	8,144,974	17,514,957	15.00

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 15-0115 | Period: From 07/01/2021 To 06/30/2022 | Worksheet E Part A Exhibit 4 | Date/Time Prepared: 11/29/2022 11:30 am

Title XVIII | Hospital | PPS

		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	1,228,545	0	309,661	918,884	1,228,545	16.00
17.00	Special add-on payments for new technologies	54.00	146,066	0	48,689	97,377	146,066	17.00
17.01	Net organ aquisition cost							17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			0	9,728,333	9,161,235	18,889,568	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	1,101,594	0	277,662	823,932	1,101,594	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	488	0	123	365	488	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.1148	0.1148	0.1148	0.1148		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	126,463	0	31,876	94,587	126,463	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	1,228,545	0	309,661	918,884	1,228,545	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.011894	0.039167		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			115,709		115,709	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				358,818	358,818	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0115	Period: From 07/01/2021 To 06/30/2022	Worksheet E Part B Date/Time Prepared: 11/29/2022 11:30 am
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	7,735	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	25,475,221	2.00
3.00	OPPS payments	27,217,582	3.00
4.00	Outlier payment (see instructions)	32,660	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	7,735	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	38,889	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)	38,889	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)	38,889	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	31,154	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	7,735	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)	27,250,242	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	4,778,927	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)	22,479,050	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	426,979	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)	22,906,029	30.00
31.00	Primary payer payments	6,734	31.00
32.00	Subtotal (line 30 minus line 31)	22,899,295	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)	85,118	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	55,327	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	27,715	36.00
37.00	Subtotal (see instructions)	22,954,622	37.00
38.00	MSP-LCC reconciliation amount from PS&R	-35	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)	22,954,657	40.00
40.01	Sequestration adjustment (see instructions)	57,387	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	22,969,412	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)	-72,142	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: 15-0115	Period: From 07/01/2021 To 06/30/2022	Worksheet E Part B Date/Time Prepared: 11/29/2022 11:30 am
	Title XVIII	Hospital	PPS

		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: 15-0115 | Period: From 07/01/2021 To 06/30/2022 | Worksheet E-1 Part I Date/Time Prepared: 11/29/2022 11:30 am

Title XVIII | Hospital | PPS

		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		16,220,814		22,875,212	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	03/16/2022	103,900	03/16/2022	94,200	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)		103,900		94,200	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)		16,324,714		22,969,412	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		1,207,284		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		72,142	6.02
7.00	Total Medicare program liability (see instructions)		17,531,998		22,897,270	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: 15-0115 | Component CCN: 15-S115 | Period: From 07/01/2021 To 06/30/2022 | Worksheet E-1 Part I | Date/Time Prepared: 11/29/2022 11:30 am

Title XVIII | Subprovider - IPF | PPS

		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		219,486		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)		219,486		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		12,776		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		232,262		0	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: 15-0115 | Component CCN: 15-T115 | Period: From 07/01/2021 To 06/30/2022 | Worksheet E-1 Part I | Date/Time Prepared: 11/29/2022 11:30 am

Title XVIII | Subprovider - IRF | PPS

		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		995,329		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)		995,329		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		22,654		0	6.02
7.00	Total Medicare program liability (see instructions)		972,675		0	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: 15-0115 | Component CCN: 15-5305 | Period: From 07/01/2021 To 06/30/2022 | Worksheet E-1 Part I | Date/Time Prepared: 11/29/2022 11:30 am

Title XVIII | Skilled Nursing Facility | PPS

		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		1,604,275		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)		1,604,275		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,604,275		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: 15-0115	Period: From 07/01/2021 To 06/30/2022	Worksheet E-1 Part II Date/Time Prepared: 11/29/2022 11:30 am
	Title XVIII	Hospital	PPS

		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14		1.00
2.00	Medicare days (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	Provider CCN: 15-0115 Component CCN: 15-S115	Period: From 07/01/2021 To 06/30/2022	Worksheet E-3 Part II Date/Time Prepared: 11/29/2022 11:30 am
	Title XVIII	Subprovider - IPF	PPS

		1.00	
	PART II - MEDICARE PART A SERVICES - IPF PPS		
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)	267,006	1.00
2.00	Net IPF PPS Outlier Payments	9,870	2.00
3.00	Net IPF PPS ECT Payments	0	3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)	0.00	4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00	4.01
5.00	New Teaching program adjustment. (see instructions)	0.00	5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instuctions)	0.00	6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instuctions)	0.19	7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)	0.19	8.00
9.00	Average Daily Census (see instructions)	3.663014	9.00
10.00	Teaching Adjustment Factor {((1 + (line 8/line 9)) raised to the power of .5150 -1}.	0.026385	10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).	7,045	11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)	283,921	12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)	0	13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)		14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)	0	15.00
16.00	Subtotal (see instructions)	283,921	16.00
17.00	Primary payer payments	0	17.00
18.00	Subtotal (line 16 less line 17).	283,921	18.00
19.00	Deductibles	31,812	19.00
20.00	Subtotal (line 18 minus line 19)	252,109	20.00
21.00	Coinsurance	26,290	21.00
22.00	Subtotal (line 20 minus line 21)	225,819	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	10,808	23.00
24.00	Adjusted reimbursable bad debts (see instructions)	7,025	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	25.00
26.00	Subtotal (sum of lines 22 and 24)	232,844	26.00
27.00	Direct graduate medical education payments (see instructions)	0	27.00
28.00	Other pass through costs (see instructions)	0	28.00
29.00	Outlier payments reconciliation	0	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	30.50
30.98	Recovery of accelerated depreciation.	0	30.98
30.99	Demonstration payment adjustment amount before sequestration	0	30.99
31.00	Total amount payable to the provider (see instructions)	232,844	31.00
31.01	Sequestration adjustment (see instructions)	582	31.01
31.02	Demonstration payment adjustment amount after sequestration	0	31.02
32.00	Interim payments	219,486	32.00
33.00	Tentative settlement (for contractor use only)	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)	12,776	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	35.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Worksheet E-3, Part II, line 2	9,870	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money	0.00	52.00
53.00	Time Value of Money (see instructions)	0	53.00
	FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING BEFORE THE END OF THE COVID-19 PHE		
99.00	Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020.	0.000000	99.00
99.01	Calculated Teaching Adjustment Factor for the current year. (see instructions)	0.026385	99.01

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN:15-0115 Component CCN:15-T115	Period: From 07/01/2021 To 06/30/2022	Worksheet E-3 Part III Date/Time Prepared: 11/29/2022 11:30 am
	Title XVIII	Subprovider - IRF	PPS

		1.00	
	PART III - MEDICARE PART A SERVICES - IRF PPS		
1.00	Net Federal PPS Payment (see instructions)	963,228	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)	0.0055	2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)	11,751	3.00
4.00	Outlier Payments	3,765	4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)	0.00	5.00
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00	5.01
6.00	New Teaching program adjustment. (see instructions)	0.00	6.00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)	0.00	7.00
8.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)	0.00	8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)	0.00	9.00
10.00	Average Daily Census (see instructions)	2.624658	10.00
11.00	Teaching Adjustment Factor (see instructions)	0.000000	11.00
12.00	Teaching Adjustment (see instructions)	0	12.00
13.00	Total PPS Payment (see instructions)	978,744	13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)	0	14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)		15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)	0	16.00
17.00	Subtotal (see instructions)	978,744	17.00
18.00	Primary payer payments	0	18.00
19.00	Subtotal (line 17 less line 18).	978,744	19.00
20.00	Deductibles	4,596	20.00
21.00	Subtotal (line 19 minus line 20)	974,148	21.00
22.00	Coinsurance	0	22.00
23.00	Subtotal (line 21 minus line 22)	974,148	23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	1,484	24.00
25.00	Adjusted reimbursable bad debts (see instructions)	965	25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	26.00
27.00	Subtotal (sum of lines 23 and 25)	975,113	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	28.00
29.00	Other pass through costs (see instructions)	0	29.00
30.00	Outlier payments reconciliation	0	30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	31.00
31.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	31.50
31.98	Recovery of accelerated depreciation.	0	31.98
31.99	Demonstration payment adjustment amount before sequestration	0	31.99
32.00	Total amount payable to the provider (see instructions)	975,113	32.00
32.01	Sequestration adjustment (see instructions)	2,438	32.01
32.02	Demonstration payment adjustment amount after sequestration	0	32.02
33.00	Interim payments	995,329	33.00
34.00	Tentative settlement (for contractor use only)	0	34.00
35.00	Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)	-22,654	35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	36.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4	3,765	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money	0.00	52.00
53.00	Time Value of Money (see instructions)	0	53.00
	FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING BEFORE THE END OF THE COVID-19 PHE		
99.00	Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020.	0.000000	99.00
99.01	Calculated Teaching Adjustment Factor for the current year. (see instructions)	0.000000	99.01

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0115 Component CCN: 15-5305	Period: From 07/01/2021 To 06/30/2022	Worksheet E-3 Part VI Date/Time Prepared: 11/29/2022 11:30 am
	Title XVIII	Skilled Nursing Facility	PPS

		1.00	
	PART VI - CALCULATION OF REIMBURSEMENT SETTLEMEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES		
	PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)		
1.00	Resource Utilization Group Payment (RUGS)	1,786,619	1.00
2.00	Routine service other pass through costs	0	2.00
3.00	Ancillary service other pass through costs	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	1,786,619	4.00
	COMPUTATION OF NET COST OF COVERED SERVICES		
5.00	Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E, Part B. This line is now shaded.)		5.00
6.00	Deductible	0	6.00
7.00	Coinsurance	178,772	7.00
8.00	Allowable bad debts (see instructions)	0	8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0	9.00
10.00	Adjusted reimbursable bad debts (see instructions)	0	10.00
11.00	Utilization review	0	11.00
12.00	Subtotal (sum of lines 4, 5 minus lines 6 and 7, plus lines 10 and 11)(see instructions)	1,607,847	12.00
13.00	Inpatient primary payer payments	0	13.00
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	14.00
14.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	14.50
14.98	Recovery of accelerated depreciation.	0	14.98
14.99	Demonstration payment adjustment amount before sequestration	0	14.99
15.00	Subtotal (see instructions	1,607,847	15.00
15.01	Sequestration adjustment (see instructions)	3,572	15.01
15.02	Demonstration payment adjustment amount after sequestration	0	15.02
15.75	Sequestration for non-claims based amounts (see instructions)	0	15.75
16.00	Interim payments	1,604,275	16.00
17.00	Tentative settlement (for contractor use only)	0	17.00
18.00	Balance due provider/program (line 15 minus lines 15.01, 15.02, 15.75, 16, and 17)	0	18.00
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, chapter 1, §115.2	0	19.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0115	Period: From 07/01/2021 To 06/30/2022	Worksheet E-3 Part VII Date/Time Prepared: 11/29/2022 11:30 am
	Title XIX	Hospital	Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	681,245		1.00
2.00	Medical and other services		1,237,136	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	681,245	1,237,136	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)	681,245	1,237,136	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	1,888,050	6,448,657	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)	1,888,050	6,448,657	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)	1,888,050	6,448,657	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	1,206,805	5,211,521	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)	681,245	1,237,136	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)	681,245	1,237,136	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)	681,245	1,237,136	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)	681,245	1,237,136	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS)	-681,245	-1,237,136	37.00
38.00	Subtotal (line 36 ± line 37)	0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	0	0	40.00
41.00	Interim payments	0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0115 Component CCN: 15-S115	Period: From 07/01/2021 To 06/30/2022	Worksheet E-3 Part VII Date/Time Prepared: 11/29/2022 11:30 am
	Title XIX	Subprovider - IPF	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	932,956		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)	932,956	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)	932,956	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	0	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)	0	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)	0	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	0	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	932,956	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)	0	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)	0	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	932,956	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	0	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)	0	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	0	0	40.00
41.00	Interim payments	0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0115 Component CCN: 15-T115	Period: From 07/01/2021 To 06/30/2022	Worksheet E-3 Part VII Date/Time Prepared: 11/29/2022 11:30 am
	Title XIX	Subprovider - IRF	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	0		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)	0	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)	0	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	0	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)	0	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)	0	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	0	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)	0	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)	0	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)	0	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)	0	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	0	0	40.00
41.00	Interim payments	0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0115 Component CCN: 15-5305	Period: From 07/01/2021 To 06/30/2022	Worksheet E-3 Part VII Date/Time Prepared: 11/29/2022 11:30 am
	Title XIX	Skilled Nursing Facility	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	0		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)	0	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)	0	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	0	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)	0	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)	0	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	0	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)	0	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)	0	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)	0	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)	0	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	0	0	40.00
41.00	Interim payments	0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS | Provider CCN: 15-0115 | Period: From 07/01/2021 To 06/30/2022 | Worksheet E-4 | Date/Time Prepared: 11/29/2022 11:30 am

Title XVIII | Hospital | PPS

		1.00	
	COMPUTATION OF TOTAL DIRECT GME AMOUNT		
1.00	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.	0.00	1.00
2.00	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)	0.00	2.00
3.00	Amount of reduction to Direct GME cap under section 422 of MMA	0.00	3.00
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)	0.00	3.01
4.00	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))	0.00	4.00
4.01	ACA Section 5503 increase to the Direct GME FTE Cap (see instructions for cost reporting periods straddling 7/1/2011)	0.00	4.01
4.02	ACA Section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)	0.00	4.02
5.00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus lines 4.01 and 4.02 plus applicable subscripts	0.00	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)	0.00	6.00
7.00	Enter the lesser of line 5 or line 6	0.00	7.00

		Primary Care	Other	Total	
		1.00	2.00	3.00	
8.00	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year.	0.00	0.00	0.00	8.00
9.00	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6.	0.00	0.00	0.00	9.00
10.00	Weighted dental and podiatric resident FTE count for the current year		0.00		10.00
10.01	Unweighted dental and podiatric resident FTE count for the current year		0.00		10.01
11.00	Total weighted FTE count	0.00	0.00		11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	0.00	0.00		12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	0.00	0.00		13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	0.00	0.00		14.00
15.00	Adjustment for residents in initial years of new programs	14.23	0.50		15.00
15.01	Unweighted adjustment for residents in initial years of new programs	14.23	0.50		15.01
16.00	Adjustment for residents displaced by program or hospital closure	0.00	0.00		16.00
16.01	Unweighted adjustment for residents displaced by program or hospital closure	0.00	0.00		16.01
17.00	Adjusted rolling average FTE count	14.23	0.50		17.00
18.00	Per resident amount	105,000.00	105,000.00		18.00
19.00	Approved amount for resident costs	1,494,150	52,500	1,546,650	19.00

		1.00	
20.00	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 Sec. 413.79(c)(4)	0.00	20.00
21.00	Direct GME FTE unweighted resident count over cap (see instructions)	0.00	21.00
22.00	Allowable additional direct GME FTE Resident Count (see instructions)	0.00	22.00
23.00	Enter the locality adjustment national average per resident amount (see instructions)	0.00	23.00
24.00	Multiply line 22 time line 23	0	24.00
25.00	Total direct GME amount (sum of lines 19 and 24)	1,546,650	25.00

		Inpatient Part A	Managed Care Prior to 1/1	Managed Care On or after 1/1	Total	
		1.00	2.00	2.01	3.00	
	COMPUTATION OF PROGRAM PATIENT LOAD					
26.00	Inpatient Days (see instructions) (Title XIX - see S-2 Part IX, line 3.02, column 2)	6,046	885	1,001		26.00
27.00	Total Inpatient Days (see instructions)	16,061	16,061	16,061		27.00
28.00	Ratio of inpatient days to total inpatient days	0.376440	0.055102	0.062325		28.00
29.00	Program direct GME amount	582,221	85,224	96,395	763,840	29.00
29.01	Percent reduction for MA DGME		3.26	3.26		29.01
30.00	Reduction for direct GME payments for Medicare Advantage		2,778	3,142	5,920	30.00
31.00	Net Program direct GME amount				757,920	31.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS | Provider CCN: 15-0115 | Period: From 07/01/2021 To 06/30/2022 | Worksheet E-4 | Date/Time Prepared: 11/29/2022 11:30 am

Title XVIII | Hospital | PPS

		1.00	
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING PROGRAM AND PARAMEDICAL EDUCATION COSTS)		
32.00	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)	0	32.00
33.00	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)	0	33.00
34.00	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)	0.000000	34.00
35.00	Medicare outpatient ESRD charges (see instructions)	0	35.00
36.00	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)	0	36.00
	APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY		
	Part A Reasonable Cost		
37.00	Reasonable cost (see instructions)	19,996,122	37.00
38.00	Organ acquisition costs (Wkst. D-4, Pt. III, col. 1, line 69)	0	38.00
39.00	Cost of physicians' services in a teaching hospital (see instructions)	0	39.00
40.00	Primary payer payments (see instructions)	16,960	40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)	19,979,162	41.00
	Part B Reasonable Cost		
42.00	Reasonable cost (see instructions)	25,783,787	42.00
43.00	Primary payer payments (see instructions)	6,734	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)	25,777,053	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)	45,756,215	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)	0.436644	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)	0.563356	47.00
	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B		
48.00	Total program GME payment (line 31)	757,920	48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)	330,941	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)	426,979	50.00

		Y/N	Primary Care	Other	Total	
		0	1.00	2.00	3.00	
	E-4 Calculation - In accordance with the FY 2023 IPPS Final Rule.					
109.00	Enter in column 0, "Y" or "N" to calculate line 9 in accordance the Federal Fiscal Year 2023 Final Rule for cost reporting periods beginning prior to 10/1/2021. (see instructions)	N	0.00	0.00	0.00	109.00

If line 109 column 0 is Y, you MUST open up the PY and Penultimate cost reports and answer line 109 column 0 "Y" and calculate, then input amounts from line 11 columns 1 & 2 to the CY lines 12 & 13 columns 1 & 2 respectively.

122.00	Override of line 22 for cost reporting periods beginning prior to 10/1/2021. (see instructions)		0.00			122.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 15-0115 | Period: From 07/01/2021 To 06/30/2022 | Worksheet G | Date/Time Prepared: 11/29/2022 11:30 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	90,108,610	0	0	0	1.00
2.00	Temporary investments	66,288,549	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	22,748,602	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	0	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	7,705,076	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)	186,850,837	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	11,188,088	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	122,498,934	0	0	0	15.00
16.00	Accumulated depreciation	-85,562,330	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	158,911,560	0	0	0	19.00
20.00	Accumulated depreciation	-93,699,695	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	0	0	0	0	23.00
24.00	Accumulated depreciation	0	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)	113,336,557	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	33,003,585	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	12,955,744	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	45,959,329	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	346,146,723	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	19,137,479	0	0	0	37.00
38.00	Salaries, wages, and fees payable	27,571,519	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	4,934,039	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	5,019,859				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	1,495,471	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	58,158,367	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	64,875,000	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	64,875,000	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	123,033,367	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	223,113,356				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)	223,113,356	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	346,146,723	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-0115 | Period: From 07/01/2021 To 06/30/2022 | Worksheet G-1 | Date/Time Prepared: 11/29/2022 11:30 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		231,265,555		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		76,912,851				2.00
3.00	Total (sum of line 1 and line 2)		308,178,406		0		3.00
4.00	IDENTIFIED ON TRIAL BALANCE - FOUN.	183,378		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)		183,378		0		10.00
11.00	Subtotal (line 3 plus line 10)		308,361,784		0		11.00
12.00	HOME OFFICE DEPARTMENTS	84,758,314		0		0	12.00
13.00	FREESTANDING RHC DEPTS.	490,114		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)		85,248,428		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		223,113,356		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	IDENTIFIED ON TRIAL BALANCE - FOUN.		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	HOME OFFICE DEPARTMENTS		0		12.00
13.00	FREESTANDING RHC DEPTS.		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: 15-0115 | Period: From 07/01/2021 To 06/30/2022 | Worksheet G-2 Parts I & II Date/Time Prepared: 11/29/2022 11:30 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	26,476,761		26,476,761	1.00
2.00	SUBPROVIDER - IPF	2,377,571		2,377,571	2.00
3.00	SUBPROVIDER - IRF	1,437,352		1,437,352	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	1,637,755		1,637,755	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)	31,929,439		31,929,439	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	12,303,549		12,303,549	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)	12,303,549		12,303,549	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	44,232,988		44,232,988	17.00
18.00	Ancillary services	104,901,983	456,778,080	561,680,063	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	781,635	781,635	20.00
20.01	RURAL HEALTH CLINIC II	0	965,869	965,869	20.01
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		4,128,833	4,128,833	22.00
23.00	AMBULANCE SERVICES	1,279,371	6,211,529	7,490,900	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	PHYSICIANS	0	100,718,377	100,718,377	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	150,414,342	569,584,323	719,998,665	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		173,875,883		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)		173,875,883		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-0115 | Period: From 07/01/2021 To 06/30/2022 | Worksheet G-3 | Date/Time Prepared: 11/29/2022 11:30 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	719,998,665	1.00
2.00	Less contractual allowances and discounts on patients' accounts	474,631,619	2.00
3.00	Net patient revenues (line 1 minus line 2)	245,367,046	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	173,875,883	4.00
5.00	Net income from service to patients (line 3 minus line 4)	71,491,163	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	-10,050,264	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	596,520	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	298,853	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	MISCELLANEOUS	14,576,579	24.00
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	5,421,688	25.00
26.00	Total (line 5 plus line 25)	76,912,851	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)	76,912,851	29.00

ANALYSIS OF HOSPITAL-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 15-0115 | HHA CCN: 15-7222 | Period: From 07/01/2021 To 06/30/2022 | Worksheet H | Date/Time Prepared: 11/29/2022 11:30 am

Home Health Agency I | PPS

		Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of cols. 1 thru 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures			0		0	0	1.00
2.00	Capital Related - Movable Equipment			0		0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	0	4.00
5.00	Administrative and General	2,024,818	0	164,869	40,873	64,348	2,294,908	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	0	8.00
9.00	Speech Pathology	0	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	0	0	0	0	0	0	11.00
12.00	Supplies (see instructions)	0	0	0	0	53,025	53,025	12.00
13.00	Drugs	0	0	0	0	31,688	31,688	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	2,024,818	0	164,869	40,873	149,061	2,379,621	24.00

		Reclassification	Reclassified Trial Balance (col. 6 + col.7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)			
		7.00	8.00	9.00	10.00			
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0	0	0			1.00
2.00	Capital Related - Movable Equipment	0	0	0	0			2.00
3.00	Plant Operation & Maintenance	0	0	0	0			3.00
4.00	Transportation	0	0	0	0			4.00
5.00	Administrative and General	-1,792,010	502,898	0	502,898			5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	928,591	928,591	0	928,591			6.00
7.00	Physical Therapy	465,729	465,729	0	465,729			7.00
8.00	Occupational Therapy	250,835	250,835	0	250,835			8.00
9.00	Speech Pathology	36,165	36,165	0	36,165			9.00
10.00	Medical Social Services	9,273	9,273	0	9,273			10.00
11.00	Home Health Aide	101,417	101,417	0	101,417			11.00
12.00	Supplies (see instructions)	0	53,025	-53,025	0			12.00
13.00	Drugs	0	31,688	-31,688	0			13.00
14.00	DME	0	0	0	0			14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0			15.00
16.00	Respiratory Therapy	0	0	0	0			16.00
17.00	Private Duty Nursing	0	0	0	0			17.00
18.00	Clinic	0	0	0	0			18.00
19.00	Health Promotion Activities	0	0	0	0			19.00
20.00	Day Care Program	0	0	0	0			20.00
21.00	Home Delivered Meals Program	0	0	0	0			21.00
22.00	Homemaker Service	0	0	0	0			22.00
23.00	All Others (specify)	0	0	0	0			23.00
23.50	Telemedicine	0	0	0	0			23.50
24.00	Total (sum of lines 1-23)	0	2,379,621	-84,713	2,294,908			24.00

Column, 6 line 24 should agree with the Worksheet A, column 3, line 101, or subscript as applicable.

COST ALLOCATION - HHA GENERAL SERVICE COST | Provider CCN: 15-0115 | HHA CCN: 15-7222 | Period: From 07/01/2021 To 06/30/2022 | Worksheet H-1 Part I | Date/Time Prepared: 11/29/2022 11:30 am

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		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs: Bldgs & Fixtures	Capital Related Costs: Movable Equipment	Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)	
		0	1.00	2.00	3.00	4.00	4A.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0				0	1.00
2.00	Capital Related - Movable Equipment	0		0			0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0		0	3.00
4.00	Transportation	0	0	0	0	0		4.00
5.00	Administrative and General	502,898	0	0	0	0	502,898	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	928,591	0	0	0	0	928,591	6.00
7.00	Physical Therapy	465,729	0	0	0	0	465,729	7.00
8.00	Occupational Therapy	250,835	0	0	0	0	250,835	8.00
9.00	Speech Pathology	36,165	0	0	0	0	36,165	9.00
10.00	Medical Social Services	9,273	0	0	0	0	9,273	10.00
11.00	Home Health Aide	101,417	0	0	0	0	101,417	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0		0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	2,294,908	0	0	0	0	2,294,908	24.00

		Administrative & General	Total (cols. 4A + 5)	
		5.00	6.00	
	GENERAL SERVICE COST CENTERS			
1.00	Capital Related - Bldg. & Fixtures			1.00
2.00	Capital Related - Movable Equipment			2.00
3.00	Plant Operation & Maintenance			3.00
4.00	Transportation			4.00
5.00	Administrative and General	502,898		5.00
	HHA REIMBURSABLE SERVICES			
6.00	Skilled Nursing Care	260,594	1,189,185	6.00
7.00	Physical Therapy	130,699	596,428	7.00
8.00	Occupational Therapy	70,393	321,228	8.00
9.00	Speech Pathology	10,149	46,314	9.00
10.00	Medical Social Services	2,602	11,875	10.00
11.00	Home Health Aide	28,461	129,878	11.00
12.00	Supplies (see instructions)	0	0	12.00
13.00	Drugs	0	0	13.00
14.00	DME	0	0	14.00
	HHA NONREIMBURSABLE SERVICES			
15.00	Home Dialysis Aide Services	0	0	15.00
16.00	Respiratory Therapy	0	0	16.00
17.00	Private Duty Nursing	0	0	17.00
18.00	Clinic	0	0	18.00
19.00	Health Promotion Activities	0	0	19.00
20.00	Day Care Program	0	0	20.00
21.00	Home Delivered Meals Program	0	0	21.00
22.00	Homemaker Service	0	0	22.00
23.00	All Others (specify)	0	0	23.00
23.50	Telemedicine	0	0	23.50
24.00	Total (sum of lines 1-23)		2,294,908	24.00

COST ALLOCATION - HHA STATISTICAL BASIS | Provider CCN: 15-0115 | HHA CCN: 15-7222 | Period: From 07/01/2021 To 06/30/2022 | Worksheet H-1 Part II Date/Time Prepared: 11/29/2022 11:30 am

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		Capital Related Costs						
		Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)	Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
		1.00	2.00	3.00	4.00	5A.00	5.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0				0		1.00
2.00	Capital Related - Movable Equipment		0			0		2.00
3.00	Plant Operation & Maintenance	0	0	0		0		3.00
4.00	Transportation (see instructions)	0	0	0	0			4.00
5.00	Administrative and General	0	0	0	0	-502,898	1,792,010	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	928,591	6.00
7.00	Physical Therapy	0	0	0	0	0	465,729	7.00
8.00	Occupational Therapy	0	0	0	0	0	250,835	8.00
9.00	Speech Pathology	0	0	0	0	0	36,165	9.00
10.00	Medical Social Services	0	0	0	0	0	9,273	10.00
11.00	Home Health Aide	0	0	0	0	0	101,417	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0		0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	0	0	0	0	-502,898	1,792,010	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		502,898	25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.280633	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 15-0115 | HHA CCN: 15-7222 | Period: From 07/01/2021 To 06/30/2022 | Worksheet H-2 Part I | Date/Time Prepared: 11/29/2022 11:30 am

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	Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
		0	1.00	2.00	4.00	4A	5.00	
1.00	Administrative and General	0	31,782	23,442	92,273	147,497	23,949	1.00
2.00	Skilled Nursing Care	1,189,185	0	0	219,904	1,409,089	228,791	2.00
3.00	Physical Therapy	596,428	0	0	108,000	704,428	114,377	3.00
4.00	Occupational Therapy	321,228	0	0	64,223	385,451	62,585	4.00
5.00	Speech Pathology	46,314	0	0	3,354	49,668	8,064	5.00
6.00	Medical Social Services	11,875	0	0	2,133	14,008	2,274	6.00
7.00	Home Health Aide	129,878	0	0	19,833	149,711	24,308	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	2,294,908	31,782	23,442	509,720	2,859,852	464,348	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.					0.000000		21.00

	Cost Center Description	MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
		6.00	8.00	9.00	10.00	11.00	13.00	
1.00	Administrative and General	30,362	0	8,048	0	7,793	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	18,351	0	2.00
3.00	Physical Therapy	0	0	0	0	7,905	0	3.00
4.00	Occupational Therapy	0	0	0	0	4,275	0	4.00
5.00	Speech Pathology	0	0	0	0	222	0	5.00
6.00	Medical Social Services	0	0	0	0	226	0	6.00
7.00	Home Health Aide	0	0	0	0	2,674	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	30,362	0	8,048	0	41,446	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 15-0115 HHA CCN: 15-7222

Period: From 07/01/2021 To 06/30/2022

Worksheet H-2 Part I Date/Time Prepared: 11/29/2022 11:30 am

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	Cost Center Description	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES	INTERNS & RESIDENTS SERVICES-OTHER PRGM. COSTS	Subtotal	
		14.00	15.00	16.00	21.00	22.00	24.00	
1.00	Administrative and General	2,006	0	0	0	0	219,655	1.00
2.00	Skilled Nursing Care	0	0	4,508	0	0	1,660,739	2.00
3.00	Physical Therapy	0	0	2,824	0	0	829,534	3.00
4.00	Occupational Therapy	0	0	32	0	0	452,343	4.00
5.00	Speech Pathology	0	0	1,457	0	0	59,411	5.00
6.00	Medical Social Services	0	0	60	0	0	16,568	6.00
7.00	Home Health Aide	0	0	1,522	0	0	178,215	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	2,006	0	10,403	0	0	3,416,465	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

	Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	Allocated HHA A&G (see Part II)	Total HHA Costs			
		25.00	26.00	27.00	28.00			
1.00	Administrative and General	0	219,655					1.00
2.00	Skilled Nursing Care	0	1,660,739	114,111	1,774,850			2.00
3.00	Physical Therapy	0	829,534	56,998	886,532			3.00
4.00	Occupational Therapy	0	452,343	31,081	483,424			4.00
5.00	Speech Pathology	0	59,411	4,082	63,493			5.00
6.00	Medical Social Services	0	16,568	1,138	17,706			6.00
7.00	Home Health Aide	0	178,215	12,245	190,460			7.00
8.00	Supplies (see instructions)	0	0	0	0			8.00
9.00	Drugs	0	0	0	0			9.00
10.00	DME	0	0	0	0			10.00
11.00	Home Dialysis Aide Services	0	0	0	0			11.00
12.00	Respiratory Therapy	0	0	0	0			12.00
13.00	Private Duty Nursing	0	0	0	0			13.00
14.00	Clinic	0	0	0	0			14.00
15.00	Health Promotion Activities	0	0	0	0			15.00
16.00	Day Care Program	0	0	0	0			16.00
17.00	Home Delivered Meals Program	0	0	0	0			17.00
18.00	Homemaker Service	0	0	0	0			18.00
19.00	All Others (specify)	0	0	0	0			19.00
19.50	Telemedicine	0	0	0	0			19.50
20.00	Total (sum of lines 1-19) (2)	0	3,416,465	219,655	3,416,465			20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.			0.068711				21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 15-0115 | HHA CCN: 15-7222 | Period: From 07/01/2021 To 06/30/2022 | Worksheet H-2 Part II | Date/Time Prepared: 11/29/2022 11:30 am

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	Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	
		1.00	2.00	4.00	5A	5.00	6.00	
1.00	Administrative and General	3,758	3,758	359,666	0	147,497	3,758	1.00
2.00	Skilled Nursing Care	0	0	857,152	0	1,409,089	0	2.00
3.00	Physical Therapy	0	0	420,970	0	704,428	0	3.00
4.00	Occupational Therapy	0	0	250,333	0	385,451	0	4.00
5.00	Speech Pathology	0	0	13,075	0	49,668	0	5.00
6.00	Medical Social Services	0	0	8,316	0	14,008	0	6.00
7.00	Home Health Aide	0	0	77,305	0	149,711	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	3,758	3,758	1,986,817		2,859,852	3,758	20.00
21.00	Total cost to be allocated	31,782	23,442	509,720		464,348	30,362	21.00
22.00	Unit cost multiplier	8.457158	6.237892	0.256551		0.162368	8.079297	22.00

	Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	CAFETERIA (HOURS)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	
		8.00	9.00	10.00	11.00	13.00	14.00	
1.00	Administrative and General	0	3,758	0	12,079	0	34,693	1.00
2.00	Skilled Nursing Care	0	0	0	28,444	0	0	2.00
3.00	Physical Therapy	0	0	0	12,254	0	0	3.00
4.00	Occupational Therapy	0	0	0	6,627	0	0	4.00
5.00	Speech Pathology	0	0	0	344	0	0	5.00
6.00	Medical Social Services	0	0	0	351	0	0	6.00
7.00	Home Health Aide	0	0	0	4,145	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	0	3,758	0	64,244	0	34,693	20.00
21.00	Total cost to be allocated	0	8,048	0	41,446	0	2,006	21.00
22.00	Unit cost multiplier	0.000000	2.141565	0.000000	0.645134	0.000000	0.057821	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 15-0115
HHA CCN: 15-7222

Period: From 07/01/2021 To 06/30/2022

Worksheet H-2 Part II
Date/Time Prepared: 11/29/2022 11:30 am

Home Health Agency I

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	Cost Center Description	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (REVENUE)	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-OTHER PRGM. COSTS (ASSIGNED TIME)			
		15.00	16.00	21.00	22.00			
1.00	Administrative and General	0	0	0	0			1.00
2.00	Skilled Nursing Care	0	1,723,074	0	0			2.00
3.00	Physical Therapy	0	1,079,577	0	0			3.00
4.00	Occupational Therapy	0	12,107	0	0			4.00
5.00	Speech Pathology	0	556,921	0	0			5.00
6.00	Medical Social Services	0	23,072	0	0			6.00
7.00	Home Health Aide	0	581,820	0	0			7.00
8.00	Supplies (see instructions)	0	0	0	0			8.00
9.00	Drugs	0	0	0	0			9.00
10.00	DME	0	0	0	0			10.00
11.00	Home Dialysis Aide Services	0	0	0	0			11.00
12.00	Respiratory Therapy	0	0	0	0			12.00
13.00	Private Duty Nursing	0	0	0	0			13.00
14.00	Clinic	0	0	0	0			14.00
15.00	Health Promotion Activities	0	0	0	0			15.00
16.00	Day Care Program	0	0	0	0			16.00
17.00	Home Delivered Meals Program	0	0	0	0			17.00
18.00	Homemaker Service	0	0	0	0			18.00
19.00	All Others (specify)	0	0	0	0			19.00
19.50	Telemedicine	0	0	0	0			19.50
20.00	Total (sum of lines 1-19)	0	3,976,571	0	0			20.00
21.00	Total cost to be allocated	0	10,403	0	0			21.00
22.00	Unit cost multiplier	0.000000	0.002616	0.000000	0.000000			22.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 15-0115 | HHA CCN: 15-7222 | Period: From 07/01/2021 To 06/30/2022 | Worksheet H-3 Part I | Date/Time Prepared: 11/29/2022 11:30 am

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	Cost Center Description	From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	2.00	1,774,850		1,774,850	7,543	235.30	1.00
2.00	Physical Therapy	3.00	886,532	0	886,532	4,726	187.59	2.00
3.00	Occupational Therapy	4.00	483,424	0	483,424	2,438	198.29	3.00
4.00	Speech Pathology	5.00	63,493	0	63,493	101	628.64	4.00
5.00	Medical Social Services	6.00	17,706		17,706	53	334.08	5.00
6.00	Home Health Aide	7.00	190,460		190,460	2,547	74.78	6.00
7.00	Total (sum of lines 1-6)		3,416,465	0	3,416,465	17,408		7.00

	Cost Center Description	Cost Limits	CBSA No. (1)	Program Visits: Part A	Program Visits: Part B Not Subject to Deductibles & Coinsurance	Program Visits: Part B Subject to Deductibles		
		0	1.00	2.00	3.00	4.00	5.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care		99915	0	4,283			8.00
9.00	Physical Therapy		99915	0	3,027			9.00
10.00	Occupational Therapy		99915	0	1,529			10.00
11.00	Speech Pathology		99915	0	65			11.00
12.00	Medical Social Services		99915	0	33			12.00
13.00	Home Health Aide		99915	0	1,367			13.00
14.00	Total (sum of lines 8-13)			0	10,304			14.00

	Cost Center Description	From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Records)	Ratio (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	8.00	0	0	0	52,199	0.000000	15.00
16.00	Cost of Drugs	9.00	0	0	0	0	0.000000	16.00

	Cost Center Description	Program Visits: Part A	Program Visits: Part B Not Subject to Deductibles & Coinsurance	Program Visits: Part B Subject to Deductibles & Coinsurance	Cost of Services: Part A	Cost of Services: Part B Not Subject to Deductibles & Coinsurance	Cost of Services: Part B Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	0	4,283		0	1,007,790		1.00
2.00	Physical Therapy	0	3,027		0	567,835		2.00
3.00	Occupational Therapy	0	1,529		0	303,185		3.00
4.00	Speech Pathology	0	65		0	40,862		4.00
5.00	Medical Social Services	0	33		0	11,025		5.00
6.00	Home Health Aide	0	1,367		0	102,224		6.00
7.00	Total (sum of lines 1-6)	0	10,304		0	2,032,921		7.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 15-0115 | HHA CCN: 15-7222 | Period: From 07/01/2021 To 06/30/2022 | Worksheet H-3 Part I | Date/Time Prepared: 11/29/2022 11:30 am

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	Cost Center Description							
		6.00	7.00	8.00	9.00	10.00	11.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care							8.00
9.00	Physical Therapy							9.00
10.00	Occupational Therapy							10.00
11.00	Speech Pathology							11.00
12.00	Medical Social Services							12.00
13.00	Home Health Aide							13.00
14.00	Total (sum of lines 8-13)							14.00

	Cost Center Description	Program Covered Charges			Cost of Services			
			Part B			Part B		
		Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	0	0	0	0	0	0	15.00
16.00	Cost of Drugs		0	0		0	0	16.00

	Cost Center Description	Total Program Cost (sum of cols. 9-10)		
		12.00		
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION			
	Cost Per Visit Computation			
1.00	Skilled Nursing Care	1,007,790		1.00
2.00	Physical Therapy	567,835		2.00
3.00	Occupational Therapy	303,185		3.00
4.00	Speech Pathology	40,862		4.00
5.00	Medical Social Services	11,025		5.00
6.00	Home Health Aide	102,224		6.00
7.00	Total (sum of lines 1-6)	2,032,921		7.00

	Cost Center Description			
		12.00		
	Limitation Cost Computation			
8.00	Skilled Nursing Care			8.00
9.00	Physical Therapy			9.00
10.00	Occupational Therapy			10.00
11.00	Speech Pathology			11.00
12.00	Medical Social Services			12.00
13.00	Home Health Aide			13.00
14.00	Total (sum of lines 8-13)			14.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 15-0115 | HHA CCN: 15-7222 | Period: From 07/01/2021 To 06/30/2022 | Worksheet H-3 Part II | Date/Time Prepared: 11/29/2022 11:30 am

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	Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated		
		0	1.00	2.00	3.00	4.00		
	PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS							
1.00	Physical Therapy	66.00	0.314392	0	0	col. 2, line 2.00		1.00
2.00	Occupational Therapy							2.00
3.00	Speech Pathology							3.00
4.00	Cost of Medical Supplies	71.00	0.148754	0	0	col. 2, line 15.00		4.00
5.00	Cost of Drugs	73.00	0.199183	0	0	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

Provider CCN: 15-0115 | HHA CCN: 15-7222 | Period: From 07/01/2021 To 06/30/2022 | Worksheet H-4 Part I-II | Date/Time Prepared: 11/29/2022 11:30 am

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		Part A	Part B		
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		1.00	2.00	3.00	
	PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES				
	Reasonable Cost of Part A & Part B Services				
1.00	Reasonable cost of services (see instructions)	0	0	0	1.00
2.00	Total charges	0	0	0	2.00
	Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0	3.00
4.00	Amount 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(b)	0	0	0	4.00
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000	5.00
6.00	Total customary charges (see instructions)	0	0	0	6.00
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	0	0	7.00
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0	8.00
9.00	Primary payer amounts	0	0	0	9.00

		Part A Services	Part B Services	
		1.00	2.00	
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT			
10.00	Total reasonable cost (see instructions)	0	0	10.00
11.00	Total PPS Reimbursement - Full Episodes without Outliers	0	1,323,042	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers	0	270,806	12.00
13.00	Total PPS Reimbursement - LUPA Episodes	0	21,565	13.00
14.00	Total PPS Reimbursement - PEP Episodes	0	8,937	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	0	89,922	15.00
16.00	Total PPS Outlier Reimbursement - PEP Episodes	0	3,160	16.00
17.00	Total Other Payments	0	0	17.00
18.00	DME Payments	0	0	18.00
19.00	Oxygen Payments	0	0	19.00
20.00	Prosthetic and Orthotic Payments	0	0	20.00
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		4,753	21.00
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)	0	1,712,679	22.00
23.00	Excess reasonable cost (from line 8)	0	0	23.00
24.00	Subtotal (line 22 minus line 23)	0	1,712,679	24.00
25.00	Coinsurance billed to program patients (from your records)		0	25.00
26.00	Net cost (line 24 minus line 25)	0	1,712,679	26.00
27.00	Reimbursable bad debts (from your records)	0	0	27.00
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0	0	28.00
29.00	Total costs - current cost reporting period (line 26 plus line 27)	0	1,712,679	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	30.50
30.99	Demonstration payment adjustment amount before sequestration	0	0	30.99
31.00	Subtotal (see instructions)	0	1,712,679	31.00
31.01	Sequestration adjustment (see instructions)	0	3,678	31.01
31.02	Demonstration payment adjustment amount after sequestration	0	0	31.02
31.75	Sequestration adjustment for non-claims based amounts (see instructions)	0	0	31.75
32.00	Interim payments (see instructions)	0	1,709,002	32.00
33.00	Tentative settlement (for contractor use only)	0	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 32, and 33)	0	-1	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	35.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED HHAs FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

Provider CCN: 15-0115 HHA CCN: 15-7222 | Period: From 07/01/2021 To 06/30/2022 | Worksheet H-5 | Date/Time Prepared: 11/29/2022 11:30 am

Home Health Agency I | PPS

		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		0		1,709,002	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			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			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. H-4, Part II, column as appropriate, line 32)		0		1,709,002	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		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50			0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		1	6.02
7.00	Total Medicare program liability (see instructions)		0		1,709,001	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 15-0115	Period: From 07/01/2021 To 06/30/2022	Worksheet L Parts I-III Date/Time Prepared: 11/29/2022 11:30 am
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		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	1,101,594	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	488	2.00
2.01	Model 4 BPCI Capital DRG outlier payments	0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)	37.72	3.00
4.00	Number of interns & residents (see instructions)	14.53	4.00
5.00	Indirect medical education percentage (see instructions)	11.48	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)	126,463	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	0.00	8.00
9.00	Sum of lines 7 and 8	0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)	0.00	10.00
11.00	Disproportionate share adjustment (see instructions)	0	11.00
12.00	Total prospective capital payments (see instructions)	1,228,545	12.00
		1.00	
	PART II - PAYMENT UNDER REASONABLE COST		
1.00	Program inpatient routine capital cost (see instructions)	0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)	0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)	0	3.00
4.00	Capital cost payment factor (see instructions)	0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)	0	5.00
		1.00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS		
1.00	Program inpatient capital costs (see instructions)	0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)	0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)	0	3.00
4.00	Applicable exception percentage (see instructions)	0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)	0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)	0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)	0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)	0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)	0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)	0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)	0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)	0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)	0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)	0	14.00
15.00	Current year allowable operating and capital payment (see instructions)	0	15.00
16.00	Current year operating and capital costs (see instructions)	0	16.00
17.00	Current year exception offset amount (see instructions)	0	17.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS | Provider CCN: 15-0115 | Component CCN: 15-8507 | Period: From 07/01/2021 To 06/30/2022 | Worksheet M-1 | Date/Time Prepared: 11/29/2022 11:30 am

RHC I | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	383,737	0	383,737	-338,134	45,603	1.00
2.00	Physician Assistant	0	0	0	2,363	2,363	2.00
3.00	Nurse Practitioner	0	0	0	203,799	203,799	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	94,783	94,783	9.00
10.00	Subtotal (sum of lines 1 through 9)	383,737	0	383,737	-37,189	346,548	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	1,055	1,055	0	1,055	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	1,055	1,055	0	1,055	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	383,737	1,055	384,792	-37,189	347,603	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	12,056	12,056	0	12,056	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	1,505	1,505	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	12,056	12,056	1,505	13,561	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	59,841	59,841	-198	59,643	29.00
30.00	Administrative Costs	0	37,399	37,399	35,882	73,281	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	97,240	97,240	35,684	132,924	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	383,737	110,351	494,088	0	494,088	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-0115 | Component CCN: 15-8507 | Period: From 07/01/2021 To 06/30/2022 | Worksheet M-1 | Date/Time Prepared: 11/29/2022 11:30 am

RHC I | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	45,603		1.00
2.00	Physician Assistant	0	2,363		2.00
3.00	Nurse Practitioner	0	203,799		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	94,783		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	346,548		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		14.00
15.00	Medical Supplies	0	1,055		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	1,055		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	347,603		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	12,056		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	1,505		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	13,561		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	59,643		29.00
30.00	Administrative Costs	-1,003	72,278		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-1,003	131,921		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-1,003	493,085		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-0115 | Component CCN: 15-8508 | Period: From 07/01/2021 To 06/30/2022 | Worksheet M-1 | Date/Time Prepared: 11/29/2022 11:30 am

RHC II | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	503,774	0	503,774	-381,181	122,593	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	0	0	0	174,588	174,588	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	130,337	130,337	9.00
10.00	Subtotal (sum of lines 1 through 9)	503,774	0	503,774	-76,256	427,518	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	751	751	0	751	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	751	751	0	751	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	503,774	751	504,525	-76,256	428,269	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	13,650	13,650	0	13,650	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	288	288	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	13,650	13,650	288	13,938	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	3,189	3,189	0	3,189	29.00
30.00	Administrative Costs	0	32,341	32,341	75,968	108,309	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	35,530	35,530	75,968	111,498	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	503,774	49,931	553,705	0	553,705	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-0115 | Component CCN: 15-8508 | Period: From 07/01/2021 To 06/30/2022 | Worksheet M-1 | Date/Time Prepared: 11/29/2022 11:30 am

RHC II | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	122,593		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	174,588		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	130,337		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	427,518		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		14.00
15.00	Medical Supplies	0	751		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	751		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	428,269		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	13,650		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	288		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	13,938		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	3,189		29.00
30.00	Administrative Costs	-225	108,084		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-225	111,273		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-225	553,480		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-0115 Component CCN: 15-8507

Period: From 07/01/2021 To 06/30/2022

Worksheet M-2

Date/Time Prepared: 11/29/2022 11:30 am

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	0.05	256	4,200	210		1.00
2.00	Physician Assistant	0.02	91	2,100	42		2.00
3.00	Nurse Practitioner	1.31	3,185	2,100	2,751		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.38	3,532		3,003	3,532	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)	1.38	3,532			3,532	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)					347,603	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					13,561	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					361,164	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.962452	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					131,921	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					281,719	15.00
16.00	Total overhead (sum of lines 14 and 15)					413,640	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					413,640	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					398,109	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					745,712	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-0115
Component CCN: 15-8508

Period: From 07/01/2021 To 06/30/2022

Worksheet M-2
Date/Time Prepared: 11/29/2022 11:30 am

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	0.80	1,549	4,200	3,360		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	1.34	3,603	2,100	2,814		3.00
4.00	Subtotal (sum of lines 1 through 3)	2.14	5,152		6,174	6,174	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)	2.14	5,152			6,174	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)					428,269	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					13,938	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					442,207	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.968481	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					111,273	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					430,276	15.00
16.00	Total overhead (sum of lines 14 and 15)					541,549	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					541,549	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					524,480	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					952,749	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 15-0115 Component CCN: 15-8507	Period: From 07/01/2021 To 06/30/2022	Worksheet M-3 Date/Time Prepared: 11/29/2022 11:30 am
	Title XVIII	RHC I	Cost

				1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			745,712	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			17,876	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			727,836	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			3,532	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)			3,532	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			206.07	7.00
		Calculation of Limit (1)			
		Rate Period 1 (07/01/2021 through 12/31/2021)	Rate Period 2 (01/01/2022 through 06/30/2022)		
		1.00	2.00		
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	100.00	113.00		8.00
9.00	Rate for Program covered visits (see instructions)	100.00	113.00		9.00
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	632	539		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	63,200	60,907		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	124,107		16.00
16.01	Total program charges (see instructions)(from contractor's records)		250,993		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		3,079		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		1,522		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.)		74,107		16.04
16.05	Total program cost (see instructions)	0	75,629		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		29,951		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		43,593		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		75,629		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		10,739		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		86,368		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)		86,368		26.00
26.01	Sequestration adjustment (see instructions)		216		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		73,021		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)		13,131		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: 15-0115 Component CCN: 15-8508	Period: From 07/01/2021 To 06/30/2022	Worksheet M-3 Date/Time Prepared: 11/29/2022 11:30 am
	Title XVIII	RHC II	Cost

				1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			952,749	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			20,956	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			931,793	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			6,174	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)			6,174	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			150.92	7.00
		Calculation of Limit (1)			
		Rate Period 1 (07/01/2021 through 12/31/2021)	Rate Period 2 (01/01/2022 through 06/30/2022)		
		1.00	2.00		
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	100.00	113.00		8.00
9.00	Rate for Program covered visits (see instructions)	100.00	113.00		9.00
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	809	848		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	80,900	95,824		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	176,724		16.00
16.01	Total program charges (see instructions)(from contractor's records)		302,418		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		904		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		528		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.)		104,320		16.04
16.05	Total program cost (see instructions)	0	104,848		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		45,796		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		51,143		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		104,848		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		13,595		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		118,443		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)		118,443		26.00
26.01	Sequestration adjustment (see instructions)		296		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		102,024		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)		16,123		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: 15-0115 | Component CCN: 15-8507 | Period: From 07/01/2021 To 06/30/2022 | Worksheet M-4 | Date/Time Prepared: 11/29/2022 11:30 am

Title XVIII | RHC I | Cost

		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	346,548	346,548	346,548	346,548	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.003940	0.002853	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	1,365	989	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	3,098	2,881	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	4,463	3,870	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	347,603	347,603	347,603	347,603	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	398,109	398,109	398,109	398,109	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.012839	0.011133	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	5,111	4,432	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	9,574	8,302	0	0	10.00
11.00	Total number of injections/infusions (from your records)	17	123	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	563.18	67.50	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	9	84	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)	5,069	5,670	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)		17,876			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)		10,739			16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 15-0115 | Component CCN: 15-8508 | Period: From 07/01/2021 To 06/30/2022 | Worksheet M-4 | Date/Time Prepared: 11/29/2022 11:30 am

Title XVIII | RHC II | Cost

		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	427,518	427,518	427,518	427,518	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000444	0.002868	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	190	1,226	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	4,374	3,630	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	4,564	4,856	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	428,269	428,269	428,269	428,269	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	524,480	524,480	524,480	524,480	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.010657	0.011339	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	5,589	5,947	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	10,153	10,803	0	0	10.00
11.00	Total number of injections/infusions (from your records)	24	155	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	423.04	69.70	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	15	104	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)	6,346	7,249	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)		20,956			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)		13,595			16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 15-0115 Component CCN: 15-8507	Period: From 07/01/2021 To 06/30/2022	Worksheet M-5 Date/Time Prepared: 11/29/2022 11:30 am
		RHC I	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		73,021	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)		73,021	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		13,131	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		86,152	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: 15-0115 Component CCN: 15-8508	Period: From 07/01/2021 To 06/30/2022	Worksheet M-5 Date/Time Prepared: 11/29/2022 11:30 am
		RHC II	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		102,024	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)		102,024	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		16,123	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		118,147	7.00

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