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: 15-1315	Period: From 10/01/2021 To 09/30/2022	Worksheet S Parts I-III Date/Time Prepared: 2/22/2023 3:06 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 2/22/2023 Time: 3:06 pm
2. [ ] Manually prepared cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

5. [1] Cost Report Status
   (1) As Submitted
   (2) Settled without Audit
   (3) Settled with Audit
   (4) Reopened
   (5) Amended
6. Date Received: 02/25/2022
7. Contractor No. 08001
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 CAMERON MEMORIAL COMMUNITY HOSPITAL (15-1315) for the cost reporting period beginning 10/01/2021 and ending 09/30/2022 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR		CHECKBOX	ELECTRONIC SIGNATURE STATEMENT	
	1		2		
1	Angie Logan		Y	I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name	Angie Logan			2
3	Signatory Title	PRESIDENT / CEO			3
4	Date	02/22/2023 03:06:39 PM			4

Encryption Information
ECR: Date: 2/22/2023 Time: 3:06 pm
DyVnpsCPtdXEa5VXtfQhZya15hyvn0
MB6I20vFRS.IhkqO1gNbZFUaP1vC:s
2Ain14j9yN04D5M6

PART III - SETTLEMENT SUMMARY

		Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital	0	52,697	-8,988	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing Bed - SNF	0	89,758	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	RURAL HEALTH CLINIC I	0		-6,484		0	10.00
10.01	RURAL HEALTH CLINIC II	0		-16,640		0	10.01
10.02	RURAL HEALTH CLINIC III	0		359		0	10.02
200.00	Total	0	142,455	-31,753	0	0	200.00

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

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete and review the information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.
Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents , please contact 1-800-MEDICARE.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1315 | Period: From 10/01/2021 To 09/30/2022 | Worksheet S-2 Part I Date/Time Prepared: 2/22/2023 3:06 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 416 E MAUMEE STREET	PO Box:			1.00
2.00	City: ANGOLA	State: IN	Zip Code: 47803-	County: STEUBEN	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	CAMERON MEMORIAL COMMUNITY HOSPITAL	151315	99915	1	02/01/2003	N	O	P	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	CAMERON MEMORIAL COMMUNITY	15Z315	99915		02/01/2003	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC	CAMERON FAMILY MEDICINE	158530	99915		12/31/2016	N	O	O	15.00
15.01	Hospital-Based Health Clinic - RHC II	CAMERON URGENT CARE	158545	99915		11/26/2019	N	O	O	15.01
15.02	Hospital-Based Health Clinic - RHC III	CAMERON OB/GYN	158546	99915		11/25/2019	N	O	O	15.02
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From: 1.00	To: 2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	10/01/2021	09/30/2022	20.00
21.00	Type of Control (see instructions)	2		21.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1315 | Period: From 10/01/2021 To 09/30/2022 | Worksheet S-2 Part I | Date/Time Prepared: 2/22/2023 3:06 pm

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

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

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

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

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2.	N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.				57.00
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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1315 | Period: From 10/01/2021 To 09/30/2022 | Worksheet S-2 Part I Date/Time Prepared: 2/22/2023 3:06 pm

		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)	N	63.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1315 | Period: From 10/01/2021 To 09/30/2022 | Worksheet S-2 Part I Date/Time Prepared: 2/22/2023 3:06 pm

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1315 | Period: From 10/01/2021 To 09/30/2022 | Worksheet S-2 Part I Date/Time Prepared: 2/22/2023 3:06 pm

		1.00	2.00	3.00	
	Inpatient Psychiatric Facility PPS				
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N			70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	71.00
	Inpatient Rehabilitation Facility PPS				
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N			75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	76.00

		1.00	
	Long Term Care Hospital PPS		
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N	80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.	N	81.00
	TEFRA Providers		
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.		86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	N	87.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1315 | Period: From 10/01/2021 To 09/30/2022 | Worksheet S-2 Part I Date/Time Prepared: 2/22/2023 3:06 pm

				V	XIX	
				1.00	2.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.			N		108.00
		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N	109.00
					1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration)for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.				N	110.00
				1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.			N		111.00
			1.00	2.00	3.00	
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.		N			112.00
	Miscellaneous Cost Reporting Information					
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.		N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.		N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.		Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.		1			118.00
			Premiums	Losses	Insurance	
			1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:		163,275	0	0	118.01
				1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.			N		118.02
119.00	DO NOT USE THIS LINE					119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.			N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.			Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.			Y	5.00	122.00
	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: 15-1315 | Period: From 10/01/2021 To 09/30/2022 | Worksheet S-2 Part I | Date/Time Prepared: 2/22/2023 3:06 pm

		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:	Contractor's Name:	Contractor's Number:	141.00
142.00	Street:	PO Box:		142.00
143.00	City:	State:	Zip Code:	143.00

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

		1.00	2.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.			145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	Y	07/07/2022	146.00

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1315	Period: From 10/01/2021 To 09/30/2022	Worksheet S-2 Part I Date/Time Prepared: 2/22/2023 3:06 pm

		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: 15-1315 | Period: From 10/01/2021 To 09/30/2022 | Worksheet S-2 Part II | Date/Time Prepared: 2/22/2023 3:06 pm

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

		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y			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	12/20/2022	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)	N		N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	01/31/2023	Y	01/31/2023	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1315 | Period: From 10/01/2021 To 09/30/2022 | Worksheet S-2 Part II | Date/Time Prepared: 2/22/2023 3:06 pm

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

		1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)		
	Capital Related Cost		
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions	N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.	N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions	N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.	N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.	N	27.00
	Interest Expense		
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.	N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions	Y	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	N	31.00
	Purchased Services		
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.	Y	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.	Y	33.00
	Provider-Based Physicians		
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.	Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.	Y	35.00

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

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DAVID	GOODMAN	41.00
42.00	Enter the employer/company name of the cost report preparer.	WIPFLI LLP		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	608.270.2962	DGOODMAN@WIPFLI.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-1315	Period: From 10/01/2021 To 09/30/2022	Worksheet S-2 Part II Date/Time Prepared: 2/22/2023 3:06 pm

		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	CPA		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: 15-1315 | Period: From 10/01/2021 To 09/30/2022 | Worksheet S-3 Part I Date/Time Prepared: 2/22/2023 3:06 pm

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	23	8,395	79,344.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		23	8,395	79,344.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	2	730	2,822.40	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		25	9,125	82,166.40	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	116.00	0	0			24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	88.00				0	26.00
26.01	RURAL HEALTH CLINIC II	88.01				0	26.01
26.02	RURAL HEALTH CLINIC III	88.02				0	26.02
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		25				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1315 | Period: From 10/01/2021 To 09/30/2022 | Worksheet S-3 Part I | Date/Time Prepared: 2/22/2023 3:06 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,007	61	3,697			1.00
2.00	HMO and other (see instructions)	1,353	0				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	552	0	1,262			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	95			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,559	61	5,054			7.00
8.00	INTENSIVE CARE UNIT	36	4	130			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	344			13.00
14.00	Total (see instructions)	1,595	78	5,528	0.00	415.70	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0	0	0	0.00	0.00	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0	0	0	0.00	0.00	24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	1,160	0	9,558	0.00	10.09	26.00
26.01	RURAL HEALTH CLINIC II	1,201	0	18,746	0.00	13.85	26.01
26.02	RURAL HEALTH CLINIC III	125	0	5,617	0.00	8.76	26.02
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	448.40	27.00
28.00	Observation Bed Days		0	1,816			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	96			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: 15-1315 | Period: From 10/01/2021 To 09/30/2022 | Worksheet S-3 Part I | Date/Time Prepared: 2/22/2023 3:06 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	277	19	1,133	1.00
2.00	HMO and other (see instructions)			326	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	277	19	1,133	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0.00					24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0.00					26.00
26.01	RURAL HEALTH CLINIC II	0.00					26.01
26.02	RURAL HEALTH CLINIC III	0.00					26.02
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-1315 | Component CCN: 15-8530 | Period: From 10/01/2021 To 09/30/2022 | Worksheet S-8 | Date/Time Prepared: 2/22/2023 3:06 pm

RHC I | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			1500 W MAUMEE STREET		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	ANGOLOA		IN	46703	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	16:30	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		STEUBEN				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	16:30	08:00	16:30	16:30	17:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-1315 | Component CCN: 15-8530 | Period: From 10/01/2021 To 09/30/2022 | Worksheet S-8 | Date/Time Prepared: 2/22/2023 3:06 pm

RHC I | Cost

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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-1315 | Component CCN: 15-8545 | Period: From 10/01/2021 To 09/30/2022 | Worksheet S-8 | Date/Time Prepared: 2/22/2023 3:06 pm

RHC II | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			1381 N. WAYNE STREET		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	ANGOLA		IN	46703	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	09:00	17:30	08:00	19:30	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						2.00

		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC	19:30	08:00	19:30	08:00	19:30	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 15-1315
Component CCN: 15-8545

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

Worksheet S-8
Date/Time Prepared:
2/22/2023 3:06 pm

RHC II | Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	08:00	19:30	09:00	17:30		11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-1315 | Component CCN: 15-8546 | Period: From 10/01/2021 To 09/30/2022 | Worksheet S-8 | Date/Time Prepared: 2/22/2023 3:06 pm

RHC III | Cost

					1.00	
	Clinic Address and Identification					
1.00	Street			306 E. MAUMEE STREET SUITE 101		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	ANGOLA		IN	46703	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	16:30	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						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	16:30	08:00	16:30	08:00	16:30	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA	Provider CCN: 15-1315 Component CCN: 15-8546	Period: From 10/01/2021 To 09/30/2022	Worksheet S-8 Date/Time Prepared: 2/22/2023 3:06 pm
		RHC III	Cost

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

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 15-1315	Period: From 10/01/2021 To 09/30/2022	Worksheet S-10 Date/Time Prepared: 2/22/2023 3:06 pm

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.333759	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	10,355,351	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	Y	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	35,530,239	6.00
7.00	Medicaid cost (line 1 times line 6)	11,858,537	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)	1,503,186	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)	1,503,186	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)	163,633	0	163,633	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	54,614	0	54,614	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)	54,614	0	54,614	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)	4,139,025	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	317,582	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	488,588	27.01
28.00	Non-Medicare bad debt expense (see instructions)	3,650,437	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	1,389,372	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,443,986	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	2,947,172	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1315 | Period: From 10/01/2021 To 09/30/2022 | Worksheet A | Date/Time Prepared: 2/22/2023 3:06 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		4,868,847	4,868,847	189,046	5,057,893	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,917,367	1,917,367	1,217,171	3,134,538	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	461,709	10,933,249	11,394,958	-1,172,845	10,222,113	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	6,571,920	7,969,292	14,541,212	-206,121	14,335,091	5.00
7.00	00700	OPERATION OF PLANT	1,120,084	3,537,134	4,657,218	0	4,657,218	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	37,968	37,968	142,721	180,689	8.00
9.00	00900	HOUSEKEEPING	924,700	603,186	1,527,886	-142,721	1,385,165	9.00
10.00	01000	DIETARY	522,978	522,618	1,045,596	-52,280	993,316	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	597,961	154,296	752,257	0	752,257	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	221,337	201,960	423,297	0	423,297	14.00
15.00	01500	PHARMACY	495,971	5,221,984	5,717,955	-4,766,467	951,488	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	729,925	224,389	954,314	0	954,314	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,214,584	1,979,359	6,193,943	-142,022	6,051,921	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	93,341	93,341	31.00
43.00	04300	NURSERY	0	0	0	16,263	16,263	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,657,924	1,367,686	3,025,610	-782,325	2,243,285	50.00
51.00	05100	RECOVERY ROOM	0	0	0	782,325	782,325	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	52,289	2,750	55,039	32,418	87,457	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,265,781	1,160,728	3,426,509	0	3,426,509	54.00
60.00	06000	LABORATORY	1,152,331	2,227,713	3,380,044	0	3,380,044	60.00
65.00	06500	RESPIRATORY THERAPY	973,615	511,089	1,484,704	-205,470	1,279,234	65.00
65.01	06501	SLEEP LAB	0	0	0	70,666	70,666	65.01
66.00	06600	PHYSICAL THERAPY	1,172,707	65,513	1,238,220	0	1,238,220	66.00
69.00	06900	ELECTROCARDIOLOGY	0	4,894	4,894	134,804	139,698	69.00
69.01	06901	CARDIAC REHABILITATION	61,777	8,058	69,835	0	69,835	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	2,471,029	2,471,029	-1,570,686	900,343	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,570,686	1,570,686	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	2,124,164	2,124,164	73.00
76.00	03020	CHEMICAL DEPENDENCY	0	0	0	0	0	76.00
76.01	03480	ONCOLOGY	0	2,021,885	2,021,885	0	2,021,885	76.01
76.02	03030	DIABETIC EDUCATION	0	85,051	85,051	0	85,051	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,085,301	111,857	1,197,158	171,383	1,368,541	88.00
88.01	08801	RURAL HEALTH CLINIC II	1,577,593	267,283	1,844,876	217,677	2,062,553	88.01
88.02	08802	RURAL HEALTH CLINIC III	1,120,051	305,770	1,425,821	147,513	1,573,334	88.02
90.00	09000	CLINIC	109,090	16,438	125,528	0	125,528	90.00
90.01	09001	CLINIC- ORTHO	327,585	1,045,835	1,373,420	28,783	1,402,203	90.01
90.02	09002	CLINIC - PEDS ENT FP	1,116,107	61,454	1,177,561	256,616	1,434,177	90.02
90.03	09003	INTRAVENOUS THERAPY	91,327	17,349	108,676	2,578,933	2,687,609	90.03
90.04	09004	PSYCHIATRY	710,808	28,381	739,189	76,040	815,229	90.04
90.05	09005	CARDIOLOGY	1,162,689	65,363	1,228,052	80,878	1,308,930	90.05
91.00	09100	EMERGENCY	2,449,765	373,878	2,823,643	0	2,823,643	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		1,324,269	1,324,269	-1,324,269	0	113.00
114.00	11400	UTILIZATION REVIEW-SNF	0	0	0	0	0	114.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	32,947,909	51,715,922	84,663,831	-433,778	84,230,053	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	0	0	0	0	192.00
194.00	07950	DAYCARE-INFANT/TODDLER	0	0	0	0	0	194.00
194.01	07951	MOB	0	0	0	0	0	194.01
194.02	07952	COMMUNITY HEALTH	64,400	27,260	91,660	0	91,660	194.02
194.03	07953	ASSISTED LIVING/CAMERON WOODS	0	0	0	0	0	194.03
194.04	07954	EDUCATION	0	0	0	0	0	194.04
194.05	07955	MARKETING	80,430	653,370	733,800	114,293	848,093	194.05
194.06	07956	GUEST MEALS	0	0	0	52,280	52,280	194.06
194.07	07957	OUTSIDE LAUNDRY	0	0	0	0	0	194.07
194.08	07958	CANCER CENTER	0	0	0	0	0	194.08
194.09	07959	URGENT CARE	0	0	0	0	0	194.09
194.10	07960	RHC	0	0	0	0	0	194.10
194.11	07961	OBGYN	0	0	0	0	0	194.11
194.12	07962	TRINE STUDENT HEALTH	136,310	5,553	141,863	0	141,863	194.12
194.13	07963	OCCUPATIONAL HEALTH	291,786	179,584	471,370	18,813	490,183	194.13
194.14	07964	IMMUNIZATION CLINIC	0	0	0	0	0	194.14

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1315 | Period: From 10/01/2021 To 09/30/2022 | Worksheet A | Date/Time Prepared: 2/22/2023 3:06 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
194.15	07965	FOUNDATION	144,816	163,394	308,210	808	309,018	194.15
194.16	07967	CAMERON FAMILY MEDICINE - NORTH	822,339	88,718	911,057	158,327	1,069,384	194.16
194.17	07966	CAMERON FAMILY MEDICINE - FREMONT	614,925	69,222	684,147	89,257	773,404	194.17
200.00		TOTAL (SUM OF LINES 118 through 199)	35,102,915	52,903,023	88,005,938	0	88,005,938	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1315 | Period: From 10/01/2021 To 09/30/2022 | Worksheet A | Date/Time Prepared: 2/22/2023 3:06 pm

		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	-194,902	4,862,991		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-139,747	2,994,791		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-226,924	9,995,189		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-2,791,774	11,543,317		5.00
7.00	00700	OPERATION OF PLANT	0	4,657,218		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	180,689		8.00
9.00	00900	HOUSEKEEPING	0	1,385,165		9.00
10.00	01000	DIETARY	-268,979	724,337		10.00
11.00	01100	CAFETERIA	0	0		11.00
13.00	01300	NURSING ADMINISTRATION	0	752,257		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-3,300	419,997		14.00
15.00	01500	PHARMACY	-11,696	939,792		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-899	953,415		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-867,878	5,184,043		30.00
31.00	03100	INTENSIVE CARE UNIT	0	93,341		31.00
43.00	04300	NURSERY	0	16,263		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-672,558	1,570,727		50.00
51.00	05100	RECOVERY ROOM	0	782,325		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	87,457		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,426,509		54.00
60.00	06000	LABORATORY	-3,335	3,376,709		60.00
65.00	06500	RESPIRATORY THERAPY	0	1,279,234		65.00
65.01	06501	SLEEP LAB	0	70,666		65.01
66.00	06600	PHYSICAL THERAPY	-3,025	1,235,195		66.00
69.00	06900	ELECTROCARDIOLOGY	0	139,698		69.00
69.01	06901	CARDIAC REHABILITATION	-1,247	68,588		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	900,343		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,570,686		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,124,164		73.00
76.00	03020	CHEMICAL DEPENDENCY	0	0		76.00
76.01	03480	ONCOLOGY	-32,168	1,989,717		76.01
76.02	03030	DIABETIC EDUCATION	0	85,051		76.02
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	1,368,541		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	2,062,553		88.01
88.02	08802	RURAL HEALTH CLINIC III	-293,044	1,280,290		88.02
90.00	09000	CLINIC	0	125,528		90.00
90.01	09001	CLINIC- ORTHO	-1,171,691	230,512		90.01
90.02	09002	CLINIC - PEDS ENT FP	-766,428	667,749		90.02
90.03	09003	INTRAVENOUS THERAPY	0	2,687,609		90.03
90.04	09004	PSYCHIATRY	-517,034	298,195		90.04
90.05	09005	CARDIOLOGY	-776,769	532,161		90.05
91.00	09100	EMERGENCY	0	2,823,643		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	0		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
114.00	11400	UTILIZATION REVIEW-SNF	0	0		114.00
116.00	11600	HOSPICE	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-8,743,398	75,486,655		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0		192.00
194.00	07950	DAYCARE-INFANT/TODDLER	0	0		194.00
194.01	07951	MOB	0	0		194.01
194.02	07952	COMMUNITY HEALTH	0	91,660		194.02
194.03	07953	ASSISTED LIVING/CAMERON WOODS	0	0		194.03
194.04	07954	EDUCATION	0	0		194.04
194.05	07955	MARKETING	0	848,093		194.05
194.06	07956	GUEST MEALS	0	52,280		194.06
194.07	07957	OUTSIDE LAUNDRY	0	0		194.07
194.08	07958	CANCER CENTER	0	0		194.08
194.09	07959	URGENT CARE	0	0		194.09
194.10	07960	RHC	0	0		194.10
194.11	07961	OBGYN	0	0		194.11
194.12	07962	TRINE STUDENT HEALTH	0	141,863		194.12
194.13	07963	OCCUPATIONAL HEALTH	0	490,183		194.13
194.14	07964	IMMUNIZATION CLINIC	0	0		194.14
194.15	07965	FOUNDATION	0	309,018		194.15

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1315 | Period: From 10/01/2021 To 09/30/2022 | Worksheet A | Date/Time Prepared: 2/22/2023 3:06 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
194.16	07967	CAMERON FAMILY MEDICINE - NORTH	0	1,069,384		194.16
194.17	07966	CAMERON FAMILY MEDICINE - FREMONT	0	773,404		194.17
200.00		TOTAL (SUM OF LINES 118 through 199)	-8,743,398	79,262,540		200.00

RECLASSIFICATIONS | Provider CCN: 15-1315 | Period: From 10/01/2021 To 09/30/2022 | Worksheet A-6 | Date/Time Prepared: 2/22/2023 3:06 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - LABOR AND DELIVERY				
1.00	NURSERY	43.00	10,166	6,097	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	20,265	12,153	2.00
	TOTALS		30,431	18,250	
	B - PROPERTY INSURANCE				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	71,729	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	13,373	2.00
	TOTALS		0	85,102	
	C - CAFETERIA				
1.00	GUEST MEALS	194.06	26,149	26,131	1.00
	TOTALS		26,149	26,131	
	D - INTEREST EXPENSE				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,318,618	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	5,651	2.00
	TOTALS		0	1,324,269	
	E - DEPRECIATION EXPENSE				
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	1,198,147	1.00
	TOTALS		0	1,198,147	
	F - ICU				
1.00	INTENSIVE CARE UNIT	31.00	79,191	14,150	1.00
	TOTALS		79,191	14,150	
	G - PROPERTY TAX				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	5,918	1.00
	TOTALS		0	5,918	
	H - SLEEP LAB - EKG				
1.00	SLEEP LAB	65.01	30,831	39,835	1.00
2.00	ELECTROCARDIOLOGY	69.00	22,659	21,146	2.00
	TOTALS		53,490	60,981	
	I - PUBLIC RELATIONS				
1.00	MARKETING	194.05	0	114,293	1.00
	TOTALS		0	114,293	
	J - RECOVERY ROOM				
1.00	RECOVERY ROOM	51.00	782,325	0	1.00
	TOTALS		782,325	0	
	K - IMPLANTABLE DEVICES				
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	1,570,686	1.00
	TOTALS		0	1,570,686	
	L - FOUNDATION RECLASS				
1.00	FOUNDATION	194.15	808	0	1.00
	TOTALS		808	0	
	M - IMMUNIZATION CLINIC RECLASS				
1.00	CLINIC - PEDS ENT FP	90.02	0	63,370	1.00
	TOTALS		0	63,370	
	N - DRUGS RECLASS				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	4,703,097	1.00
	TOTALS		0	4,703,097	
	O - IV THERAPY				
1.00	INTRAVENOUS THERAPY	90.03	0	2,578,933	1.00
	TOTALS		0	2,578,933	
	P - EKG HST RECLASS				
1.00	ELECTROCARDIOLOGY	69.00	90,999	0	1.00
	TOTALS		90,999	0	
	Q - OFFSITE DEPRECIATION				
1.00	CAMERON FAMILY MEDICINE - NORTH	194.16	0	5,232	1.00
2.00	CAMERON FAMILY MEDICINE - FREMONT	194.17	0	3,840	2.00
	TOTALS		0	9,072	
	R - PROVIDER BENEFITS				
1.00	RURAL HEALTH CLINIC	88.00	0	153,741	1.00
2.00	RURAL HEALTH CLINIC II	88.01	0	217,677	2.00
3.00	RURAL HEALTH CLINIC III	88.02	0	147,513	3.00
4.00	CLINIC- ORTHO	90.01	0	28,783	4.00
5.00	CLINIC - PEDS ENT FP	90.02	0	193,246	5.00
6.00	PSYCHIATRY	90.04	0	93,682	6.00
7.00	CARDIOLOGY	90.05	0	80,878	7.00
8.00	OCCUPATIONAL HEALTH	194.13	0	18,813	8.00
9.00	CAMERON FAMILY MEDICINE - NORTH	194.16	0	153,095	9.00
10.00	CAMERON FAMILY MEDICINE - FREMONT	194.17	0	85,417	10.00
	TOTALS		0	1,172,845	

RECLASSIFICATIONS | Provider CCN: 15-1315 | Period: From 10/01/2021 To 09/30/2022 | Worksheet A-6 | Date/Time Prepared: 2/22/2023 3:06 pm

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	S - PSYCH PROVIDER TIME				
1.00	RURAL HEALTH CLINIC	88.00	17,642	0	1.00
	TOTALS		17,642	0	
	T - LAUNDRY RECLASS				
1.00	LAUNDRY & LINEN SERVICE	8.00	0	142,721	1.00
	TOTALS		0	142,721	
500.00	Grand Total: Increases		1,081,035	13,087,965	500.00

RECLASSIFICATIONS | Provider CCN: 15-1315 | Period: From 10/01/2021 To 09/30/2022 | Worksheet A-6 | Date/Time Prepared: 2/22/2023 3:06 pm

		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	30,431	18,250	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		30,431	18,250			
	B - PROPERTY INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	85,102	12		1.00
2.00		0.00	0	0	12		2.00
	TOTALS		0	85,102			
	C - CAFETERIA						
1.00	DIETARY	10.00	26,149	26,131	0		1.00
	TOTALS		26,149	26,131			
	D - INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	1,324,269	11		1.00
2.00		0.00	0	0	11		2.00
	TOTALS		0	1,324,269			
	E - DEPRECIATION EXPENSE						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,198,147	9		1.00
	TOTALS		0	1,198,147			
	F - ICU						
1.00	ADULTS & PEDIATRICS	30.00	79,191	14,150	0		1.00
	TOTALS		79,191	14,150			
	G - PROPERTY TAX						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	5,918	13		1.00
	TOTALS		0	5,918			
	H - SLEEP LAB - EKG						
1.00	RESPIRATORY THERAPY	65.00	53,490	60,981	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		53,490	60,981			
	I - PUBLIC RELATIONS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	114,293	0		1.00
	TOTALS		0	114,293			
	J - RECOVERY ROOM						
1.00	OPERATING ROOM	50.00	782,325	0	0		1.00
	TOTALS		782,325	0			
	K - IMPLANTABLE DEVICES						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	1,570,686	0		1.00
	TOTALS		0	1,570,686			
	L - FOUNDATION RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	808	0	0		1.00
	TOTALS		808	0			
	M - IMMUNIZATION CLINIC RECLASS						
1.00	PHARMACY	15.00	0	63,370	0		1.00
	TOTALS		0	63,370			
	N - DRUGS RECLASS						
1.00	PHARMACY	15.00	0	4,703,097	0		1.00
	TOTALS		0	4,703,097			
	O - IV THERAPY						
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	2,578,933	0		1.00
	TOTALS		0	2,578,933			
	P - EKG HST RECLASS						
1.00	RESPIRATORY THERAPY	65.00	90,999	0	0		1.00
	TOTALS		90,999	0			
	Q - OFFSITE DEPRECIATION						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	9,072	9		1.00
2.00		0.00	0	0	9		2.00
	TOTALS		0	9,072			
	R - PROVIDER BENEFITS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1,172,845	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
10.00		0.00	0	0	0		10.00
	TOTALS		0	1,172,845			
	S - PSYCH PROVIDER TIME						
1.00	PSYCHIATRY	90.04	17,642	0	0		1.00
	TOTALS		17,642	0			

RECLASSIFICATIONS | Provider CCN: 15-1315 | Period: From 10/01/2021 To 09/30/2022 | Worksheet A-6 | Date/Time Prepared: 2/22/2023 3:06 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	T - LAUNDRY RECLASS						
1.00	HOUSEKEEPING	9.00	0	142,721	0		1.00
	TOTALS		0	142,721			
500.00	Grand Total: Decreases		1,081,035	13,087,965			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1315 | Period: From 10/01/2021 To 09/30/2022 | Worksheet A-7 Part I | Date/Time Prepared: 2/22/2023 3:06 pm

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	2,019,703	0	0	0	0	1.00
2.00	Land Improvements	0	0	0	0	0	2.00
3.00	Buildings and Fixtures	59,461,729	1,690,398	0	1,690,398	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	19,429,417	1,010,155	0	1,010,155	676,650	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	80,910,849	2,700,553	0	2,700,553	676,650	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	80,910,849	2,700,553	0	2,700,553	676,650	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	2,019,703	0	1.00
2.00	Land Improvements	0	0	2.00
3.00	Buildings and Fixtures	61,152,127	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	19,762,922	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	82,934,752	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	82,934,752	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1315 | Period: From 10/01/2021 To 09/30/2022 | Worksheet A-7 Part II | Date/Time Prepared: 2/22/2023 3:06 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	4,868,847	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	1,917,367	0	0	0	2.00
3.00	Total (sum of lines 1-2)	4,868,847	1,917,367	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL		
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	4,868,847	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	1,917,367	2.00
3.00	Total (sum of lines 1-2)	0	6,786,214	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1315 | Period: From 10/01/2021 To 09/30/2022 | Worksheet A-7 Part III Date/Time Prepared: 2/22/2023 3:06 pm

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	61,152,127	0	61,152,127	0.755757	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	19,762,921	0	19,762,921	0.244243	0	2.00
3.00	Total (sum of lines 1-2)	80,915,048	0	80,915,048	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	3,661,628	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	1,059,235	1,917,367	2.00
3.00	Total (sum of lines 1-2)	0	0	0	4,720,863	1,917,367	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	1,123,716	71,729	5,918	0	4,862,991	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	4,816	13,373	0	0	2,994,791	2.00
3.00	Total (sum of lines 1-2)	1,128,532	85,102	5,918	0	7,857,782	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1315 | Period: From 10/01/2021 To 09/30/2022 | Worksheet A-8 | Date/Time Prepared: 2/22/2023 3:06 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	A	-194,902	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	A	-835	CAP REL COSTS-MVBLE EQUIP	2.00	11	2.00
3.00	Investment income - other (chapter 2)	A	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)	B	-10,579	ADMINISTRATIVE & GENERAL	5.00	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	-4,775,693			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	-399,436			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-246,334	DIETARY	10.00	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	-11,696	PHARMACY	15.00	0	17.00
18.00	Sale of medical records and abstracts	B	-899	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	B	-4,373	DIETARY	10.00	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	UTILIZATION REVIEW-SNF	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: 15-1315 | Period: From 10/01/2021 To 09/30/2022 | Worksheet A-8 | Date/Time Prepared: 2/22/2023 3:06 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	LOBBYING EXPENSES	A	-5,547	ADMINISTRATIVE & GENERAL	5.00	0	33.00
33.01	MEALS ON WHEELS	B	-18,272	DIETARY	10.00	0	33.01
33.02	RENTAL INCOME OFFSET - CANCER CENTER	B	-32,168	ONCOLOGY	76.01	0	33.02
33.03	ATM SURCHARGE REVENUE	B	-136	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04	RHC OB PHYSICIAN & MIDLEVELS OFFSET	A	-293,044	RURAL HEALTH CLINIC III	88.02	0	33.04
33.05	MEDICAID HAF EXPENSE	A	-2,686,461	ADMINISTRATIVE & GENERAL	5.00	0	33.05
33.06	PHYSICIAN RECRUITMENT	A	-2,518	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07	MISC REVENUE	B	-56,233	ADMINISTRATIVE & GENERAL	5.00	0	33.07
33.08	OTHER PHYSICIAL THERAPY REVENUE	B	-3,025	PHYSICAL THERAPY	66.00	0	33.08
33.09	CARDIAC REHAB FITNESS REVENUE	B	-1,247	CARDIAC REHABILITATION	69.01	0	33.09
33.10	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.10
33.11	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.11
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-8,743,398				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: 15-1315 | Period: From 10/01/2021 To 09/30/2022 | Worksheet A-8-1 | Date/Time Prepared: 2/22/2023 3:06 pm

	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	2.00	CAP REL COSTS-MVBLE EQUIP	CMO AND MOB RENTAL	868,816	1,007,728	1.00
2.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	CMO EXPENSE - CAMERON WOODS	0	193,475	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	CMO EXPENSE - CAMERON WOODS	0	26,850	3.00
3.01	14.00	CENTRAL SERVICES & SUPPLY	CMO EXPENSE - CAMERON WOODS	0	3,300	3.01
4.00	5.00	ADMINISTRATIVE & GENERAL	CMO EXPENSE - CAMERON WOODS	0	3,450	4.00
4.01	4.00	EMPLOYEE BENEFITS DEPARTMENT	CMO EXPENSE - RETAIL PHARMAC	0	33,449	4.01
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			868,816	1,268,252	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	CAMERON MEDICAL	100.00		0.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 15-1315	Period: From 10/01/2021 To 09/30/2022	Worksheet A-8-1 Date/Time Prepared: 2/22/2023 3:06 pm

	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	-138,912	9		1.00
2.00	-193,475	0		2.00
3.00	-26,850	0		3.00
3.01	-3,300	0		3.01
4.00	-3,450	0		4.00
4.01	-33,449	0		4.01
5.00	-399,436			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			6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-1315 | Period: From 10/01/2021 To 09/30/2022 | Worksheet A-8-2 | Date/Time Prepared: 2/22/2023 3:06 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	867,878	867,878	0	0	0	1.00
2.00	50.00	OPERATING ROOM	672,558	672,558	0	0	0	2.00
3.00	60.00	LABORATORY	10,106	3,335	6,771	0	0	3.00
4.00	90.01	CLINIC- ORTHO	1,171,691	1,171,691	0	0	0	4.00
5.00	90.02	CLINIC - PEDS ENT FP	766,428	766,428	0	0	0	5.00
6.00	90.04	PSYCHIATRY	517,034	517,034	0	0	0	6.00
7.00	90.05	CARDIOLOGY	776,769	776,769	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			4,782,464	4,775,693	6,771		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	50.00	OPERATING ROOM	0	0	0	0	0	2.00
3.00	60.00	LABORATORY	0	0	0	0	0	3.00
4.00	90.01	CLINIC- ORTHO	0	0	0	0	0	4.00
5.00	90.02	CLINIC - PEDS ENT FP	0	0	0	0	0	5.00
6.00	90.04	PSYCHIATRY	0	0	0	0	0	6.00
7.00	90.05	CARDIOLOGY	0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	867,878		1.00
2.00	50.00	OPERATING ROOM	0	0	0	672,558		2.00
3.00	60.00	LABORATORY	0	0	0	3,335		3.00
4.00	90.01	CLINIC- ORTHO	0	0	0	1,171,691		4.00
5.00	90.02	CLINIC - PEDS ENT FP	0	0	0	766,428		5.00
6.00	90.04	PSYCHIATRY	0	0	0	517,034		6.00
7.00	90.05	CARDIOLOGY	0	0	0	776,769		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	4,775,693		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1315 | Period: From 10/01/2021 To 09/30/2022 | Worksheet B Part I | Date/Time Prepared: 2/22/2023 3:06 pm

		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	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	4,862,991	4,862,991				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2,994,791		2,994,791			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	9,995,189	39,832	20,531	10,055,552		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	11,543,317	404,236	268,462	2,306,533	14,522,548	5.00
7.00	00700	OPERATION OF PLANT	4,657,218	477,514	192,598	393,164	5,720,494	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	180,689	50,240	20,263	0	251,192	8.00
9.00	00900	HOUSEKEEPING	1,385,165	8,515	3,434	324,582	1,721,696	9.00
10.00	01000	DIETARY	724,337	280,955	113,319	174,393	1,293,004	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	752,257	31,222	33,353	209,892	1,026,724	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	419,997	147,408	59,455	77,692	704,552	14.00
15.00	01500	PHARMACY	939,792	54,639	22,038	174,092	1,190,561	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	953,415	0	21,122	256,213	1,230,750	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,184,043	883,312	356,270	1,440,895	7,864,520	30.00
31.00	03100	INTENSIVE CARE UNIT	93,341	55,822	22,515	27,797	199,475	31.00
43.00	04300	NURSERY	16,263	19,869	8,014	3,568	47,714	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,570,727	519,523	209,541	307,347	2,607,138	50.00
51.00	05100	RECOVERY ROOM	782,325	336,209	135,605	274,606	1,528,745	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	87,457	83,023	33,486	25,467	229,433	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,426,509	397,802	160,447	795,319	4,780,077	54.00
60.00	06000	LABORATORY	3,376,709	131,229	52,929	404,483	3,965,350	60.00
65.00	06500	RESPIRATORY THERAPY	1,279,234	34,534	13,929	291,034	1,618,731	65.00
65.01	06501	SLEEP LAB	70,666	0	49,609	10,822	131,097	65.01
66.00	06600	PHYSICAL THERAPY	1,235,195	298,600	120,436	411,635	2,065,866	66.00
69.00	06900	ELECTROCARDIOLOGY	139,698	17,835	7,193	39,895	204,621	69.00
69.01	06901	CARDIAC REHABILITATION	68,588	29,803	12,021	21,685	132,097	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	900,343	0	0	0	900,343	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,570,686	0	0	0	1,570,686	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,124,164	0	0	0	2,124,164	73.00
76.00	03020	CHEMICAL DEPENDENCY	0	0	0	0	0	76.00
76.01	03480	ONCOLOGY	1,989,717	0	211,793	0	2,201,510	76.01
76.02	03030	DIABETIC EDUCATION	85,051	0	0	0	85,051	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,368,541	0	129,537	139,899	1,637,977	88.00
88.01	08801	RURAL HEALTH CLINIC II	2,062,553	0	124,576	238,968	2,426,097	88.01
88.02	08802	RURAL HEALTH CLINIC III	1,280,290	0	66,705	76,705	1,423,700	88.02
90.00	09000	CLINIC	125,528	18,923	15,856	38,292	198,599	90.00
90.01	09001	CLINIC- ORTHO	230,512	0	75,864	60,077	366,453	90.01
90.02	09002	CLINIC - PEDS ENT FP	667,749	0	114,101	89,650	871,500	90.02
90.03	09003	INTRAVENOUS THERAPY	2,687,609	56,768	22,897	32,057	2,799,331	90.03
90.04	09004	PSYCHIATRY	298,195	0	33,715	55,246	387,156	90.04
90.05	09005	CARDIOLOGY	532,161	0	28,086	132,732	692,979	90.05
91.00	09100	EMERGENCY	2,823,643	451,496	182,104	859,899	4,317,142	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	75,486,655	4,829,309	2,941,804	9,694,639	75,039,073	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	27,438	11,067	0	38,505	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	1,927	0	1,927	192.00
194.00	07950	DAYCARE-INFANT/TODDLER	0	0	0	0	0	194.00
194.01	07951	MOB	0	0	0	0	0	194.01
194.02	07952	COMMUNITY HEALTH	91,660	0	0	22,605	114,265	194.02
194.03	07953	ASSISTED LIVING/CAMERON WOODS	0	0	0	0	0	194.03
194.04	07954	EDUCATION	0	0	0	0	0	194.04
194.05	07955	MARKETING	848,093	0	19,405	28,232	895,730	194.05
194.06	07956	GUEST MEALS	52,280	0	0	9,179	61,459	194.06
194.07	07957	OUTSIDE LAUNDRY	0	0	0	0	0	194.07
194.08	07958	CANCER CENTER	0	0	0	0	0	194.08
194.09	07959	URGENT CARE	0	0	0	0	0	194.09
194.10	07960	RHC	0	0	0	0	0	194.10
194.11	07961	OBGYN	0	0	0	0	0	194.11

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1315 | Period: From 10/01/2021 To 09/30/2022 | Worksheet B Part I Date/Time Prepared: 2/22/2023 3:06 pm

		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	
194.12	07962	TRINE STUDENT HEALTH	141,863	0	0	47,847	189,710	194.12
194.13	07963	OCCUPATIONAL HEALTH	490,183	0	16,161	70,536	576,880	194.13
194.14	07964	IMMUNIZATION CLINIC	0	0	0	0	0	194.14
194.15	07965	FOUNDATION	309,018	6,244	4,427	51,116	370,805	194.15
194.16	07967	CAMERON FAMILY MEDICINE - NORTH	1,069,384	0	0	72,133	1,141,517	194.16
194.17	07966	CAMERON FAMILY MEDICINE - FREMONT	773,404	0	0	59,265	832,669	194.17
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)	79,262,540	4,862,991	2,994,791	10,055,552	79,262,540	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1315 | Period: From 10/01/2021 To 09/30/2022 | Worksheet B Part I | Date/Time Prepared: 2/22/2023 3:06 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	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	14,522,548					5.00
7.00	00700	OPERATION OF PLANT	1,283,227	7,003,721				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	56,348	89,274	396,814			8.00
9.00	00900	HOUSEKEEPING	386,213	15,131	0	2,123,040		9.00
10.00	01000	DIETARY	290,048	499,245	0	78,211	2,160,508	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	230,316	55,481	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	158,046	261,938	0	7,309	0	14.00
15.00	01500	PHARMACY	267,068	97,092	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	276,083	0	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,764,182	1,569,609	366,413	696,230	2,120,384	30.00
31.00	03100	INTENSIVE CARE UNIT	44,746	99,193	6,934	21,928	40,124	31.00
43.00	04300	NURSERY	10,703	35,306	18,347	145,459	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	584,836	923,170	0	262,776	0	50.00
51.00	05100	RECOVERY ROOM	342,930	597,430	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	51,467	147,529	5,120	29,238	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,072,272	706,879	0	131,571	0	54.00
60.00	06000	LABORATORY	889,511	233,188	0	78,942	0	60.00
65.00	06500	RESPIRATORY THERAPY	363,115	61,365	0	18,274	0	65.00
65.01	06501	SLEEP LAB	29,408	0	0	5,848	0	65.01
66.00	06600	PHYSICAL THERAPY	463,417	530,600	0	63,958	0	66.00
69.00	06900	ELECTROCARDIOLOGY	45,901	31,691	0	0	0	69.00
69.01	06901	CARDIAC REHABILITATION	29,632	52,959	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	201,966	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	352,338	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	476,495	0	0	8,040	0	73.00
76.00	03020	CHEMICAL DEPENDENCY	0	0	0	0	0	76.00
76.01	03480	ONCOLOGY	493,845	0	0	1,096	0	76.01
76.02	03030	DIABETIC EDUCATION	19,079	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	367,433	0	0	17,177	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	544,225	0	0	365	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	319,366	0	0	2,193	0	88.02
90.00	09000	CLINIC	44,550	33,625	0	9,868	0	90.00
90.01	09001	CLINIC- ORTHO	82,203	0	0	66,516	0	90.01
90.02	09002	CLINIC - PEDS ENT FP	195,496	0	0	66,151	0	90.02
90.03	09003	INTRAVENOUS THERAPY	627,949	100,875	0	0	0	90.03
90.04	09004	PSYCHIATRY	86,847	0	0	0	0	90.04
90.05	09005	CARDIOLOGY	155,450	0	0	29,238	0	90.05
91.00	09100	EMERGENCY	968,426	802,289	0	374,246	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	13,575,137	6,943,869	396,814	2,114,634	2,160,508	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	8,637	48,756	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	432	0	0	0	0	192.00
194.00	07950	DAYCARE-INFANT/TODDLER	0	0	0	0	0	194.00
194.01	07951	MOB	0	0	0	0	0	194.01
194.02	07952	COMMUNITY HEALTH	25,632	0	0	0	0	194.02
194.03	07953	ASSISTED LIVING/CAMERON WOODS	0	0	0	0	0	194.03
194.04	07954	EDUCATION	0	0	0	0	0	194.04
194.05	07955	MARKETING	200,931	0	0	0	0	194.05
194.06	07956	GUEST MEALS	13,787	0	0	0	0	194.06
194.07	07957	OUTSIDE LAUNDRY	0	0	0	0	0	194.07
194.08	07958	CANCER CENTER	0	0	0	0	0	194.08
194.09	07959	URGENT CARE	0	0	0	0	0	194.09
194.10	07960	RHC	0	0	0	0	0	194.10
194.11	07961	OBGYN	0	0	0	0	0	194.11
194.12	07962	TRINE STUDENT HEALTH	42,556	0	0	0	0	194.12
194.13	07963	OCCUPATIONAL HEALTH	129,406	0	0	0	0	194.13
194.14	07964	IMMUNIZATION CLINIC	0	0	0	0	0	194.14
194.15	07965	FOUNDATION	83,179	11,096	0	0	0	194.15
194.16	07967	CAMERON FAMILY MEDICINE - NORTH	256,066	0	0	8,406	0	194.16

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1315 | Period: From 10/01/2021 To 09/30/2022 | Worksheet B Part I Date/Time Prepared: 2/22/2023 3:06 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
194.17	07966	CAMERON FAMILY MEDICINE - FREMONT	186,785	0	0	0	0	194.17
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)	14,522,548	7,003,721	396,814	2,123,040	2,160,508	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1315 | Period: From 10/01/2021 To 09/30/2022 | Worksheet B Part I | Date/Time Prepared: 2/22/2023 3:06 pm

		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
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	0					11.00
13.00	01300	NURSING ADMINISTRATION	0	1,312,521				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	1,131,845			14.00
15.00	01500	PHARMACY	0	0	7,559	1,562,280		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	365	0	1,507,198	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	470,108	97,288	0	16,500	30.00
31.00	03100	INTENSIVE CARE UNIT	0	8,970	0	0	210	31.00
43.00	04300	NURSERY	0	0	0	0	1,665	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	102,108	146,581	0	18,783	50.00
51.00	05100	RECOVERY ROOM	0	89,698	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	8,218	0	0	1,711	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	35,567	0	210,552	54.00
60.00	06000	LABORATORY	0	0	1,796	0	327,815	60.00
65.00	06500	RESPIRATORY THERAPY	0	111,739	16,128	0	48,444	65.00
65.01	06501	SLEEP LAB	0	0	0	0	953	65.01
66.00	06600	PHYSICAL THERAPY	0	156,660	4,423	0	81,418	66.00
69.00	06900	ELECTROCARDIOLOGY	0	5,980	1,138	0	56,100	69.00
69.01	06901	CARDIAC REHABILITATION	0	11,581	515	0	22,181	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	8,201	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	600,057	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	705,682	0	73.00
76.00	03020	CHEMICAL DEPENDENCY	0	0	0	0	0	76.00
76.01	03480	ONCOLOGY	0	0	0	0	29,707	76.01
76.02	03030	DIABETIC EDUCATION	0	0	73	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	9,030	0	71,129	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	67,098	0	144,802	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	4,691	0	48,182	88.02
90.00	09000	CLINIC	0	13,239	6,162	0	27,111	90.00
90.01	09001	CLINIC- ORTHO	0	0	4,912	0	27,584	90.01
90.02	09002	CLINIC - PEDS ENT FP	0	0	5,126	0	65,396	90.02
90.03	09003	INTRAVENOUS THERAPY	0	10,982	5,934	856,598	16,352	90.03
90.04	09004	PSYCHIATRY	0	0	461	0	33,993	90.04
90.05	09005	CARDIOLOGY	0	44,638	644	0	13,124	90.05
91.00	09100	EMERGENCY	0	278,600	91,597	0	134,718	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	1,312,521	1,115,346	1,562,280	1,398,430	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	0	0	0	0	192.00
194.00	07950	DAYCARE-INFANT/TODDLER	0	0	0	0	0	194.00
194.01	07951	MOB	0	0	0	0	0	194.01
194.02	07952	COMMUNITY HEALTH	0	0	57	0	0	194.02
194.03	07953	ASSISTED LIVING/CAMERON WOODS	0	0	0	0	0	194.03
194.04	07954	EDUCATION	0	0	0	0	0	194.04
194.05	07955	MARKETING	0	0	38	0	0	194.05
194.06	07956	GUEST MEALS	0	0	0	0	0	194.06
194.07	07957	OUTSIDE LAUNDRY	0	0	0	0	0	194.07
194.08	07958	CANCER CENTER	0	0	0	0	0	194.08
194.09	07959	URGENT CARE	0	0	0	0	0	194.09
194.10	07960	RHC	0	0	0	0	0	194.10
194.11	07961	OBGYN	0	0	0	0	0	194.11
194.12	07962	TRINE STUDENT HEALTH	0	0	1,288	0	18,939	194.12
194.13	07963	OCCUPATIONAL HEALTH	0	0	1,762	0	0	194.13
194.14	07964	IMMUNIZATION CLINIC	0	0	0	0	0	194.14
194.15	07965	FOUNDATION	0	0	241	0	0	194.15

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1315 | Period: From 10/01/2021 To 09/30/2022 | Worksheet B Part I Date/Time Prepared: 2/22/2023 3:06 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
194.16	07967	CAMERON FAMILY MEDICINE - NORTH	0	0	8,136	0	60,564	194.16
194.17	07966	CAMERON FAMILY MEDICINE - FREMONT	0	0	4,977	0	29,265	194.17
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)	0	1,312,521	1,131,845	1,562,280	1,507,198	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1315 | Period: From 10/01/2021 To 09/30/2022 | Worksheet B Part I | Date/Time Prepared: 2/22/2023 3:06 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			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
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	14,965,234	0	14,965,234		30.00
31.00	03100	INTENSIVE CARE UNIT	421,580	0	421,580		31.00
43.00	04300	NURSERY	259,194	0	259,194		43.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	4,645,392	0	4,645,392		50.00
51.00	05100	RECOVERY ROOM	2,558,803	0	2,558,803		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	472,716	0	472,716		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,936,918	0	6,936,918		54.00
60.00	06000	LABORATORY	5,496,602	0	5,496,602		60.00
65.00	06500	RESPIRATORY THERAPY	2,237,796	0	2,237,796		65.00
65.01	06501	SLEEP LAB	167,306	0	167,306		65.01
66.00	06600	PHYSICAL THERAPY	3,366,342	0	3,366,342		66.00
69.00	06900	ELECTROCARDIOLOGY	345,431	0	345,431		69.00
69.01	06901	CARDIAC REHABILITATION	248,965	0	248,965		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,110,510	0	1,110,510		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,523,081	0	2,523,081		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,314,381	0	3,314,381		73.00
76.00	03020	CHEMICAL DEPENDENCY	0	0	0		76.00
76.01	03480	ONCOLOGY	2,726,158	0	2,726,158		76.01
76.02	03030	DIABETIC EDUCATION	104,203	0	104,203		76.02
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	2,102,746	0	2,102,746		88.00
88.01	08801	RURAL HEALTH CLINIC II	3,182,587	0	3,182,587		88.01
88.02	08802	RURAL HEALTH CLINIC III	1,798,132	0	1,798,132		88.02
90.00	09000	CLINIC	333,154	0	333,154		90.00
90.01	09001	CLINIC- ORTHO	547,668	0	547,668		90.01
90.02	09002	CLINIC - PEDS ENT FP	1,203,669	0	1,203,669		90.02
90.03	09003	INTRAVENOUS THERAPY	4,418,021	0	4,418,021		90.03
90.04	09004	PSYCHIATRY	508,457	0	508,457		90.04
90.05	09005	CARDIOLOGY	936,073	0	936,073		90.05
91.00	09100	EMERGENCY	6,967,018	0	6,967,018		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	0	0	0		101.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
114.00	11400	UTILIZATION REVIEW-SNF					114.00
116.00	11600	HOSPICE	0	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	73,898,137	0	73,898,137		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	95,898	0	95,898		190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	2,359	0	2,359		192.00
194.00	07950	DAYCARE-INFANT/TODDLER	0	0	0		194.00
194.01	07951	MOB	0	0	0		194.01
194.02	07952	COMMUNITY HEALTH	139,954	0	139,954		194.02
194.03	07953	ASSISTED LIVING/CAMERON WOODS	0	0	0		194.03
194.04	07954	EDUCATION	0	0	0		194.04
194.05	07955	MARKETING	1,096,699	0	1,096,699		194.05
194.06	07956	GUEST MEALS	75,246	0	75,246		194.06
194.07	07957	OUTSIDE LAUNDRY	0	0	0		194.07
194.08	07958	CANCER CENTER	0	0	0		194.08
194.09	07959	URGENT CARE	0	0	0		194.09
194.10	07960	RHC	0	0	0		194.10
194.11	07961	OBGYN	0	0	0		194.11
194.12	07962	TRINE STUDENT HEALTH	252,493	0	252,493		194.12
194.13	07963	OCCUPATIONAL HEALTH	708,048	0	708,048		194.13

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1315 | Period: From 10/01/2021 To 09/30/2022 | Worksheet B Part I | Date/Time Prepared: 2/22/2023 3:06 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
194.14	07964	IMMUNIZATION CLINIC	0	0	0		194.14
194.15	07965	FOUNDATION	465,321	0	465,321		194.15
194.16	07967	CAMERON FAMILY MEDICINE - NORTH	1,474,689	0	1,474,689		194.16
194.17	07966	CAMERON FAMILY MEDICINE - FREMONT	1,053,696	0	1,053,696		194.17
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	79,262,540	0	79,262,540		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1315 | Period: From 10/01/2021 To 09/30/2022 | Worksheet B Part II | Date/Time Prepared: 2/22/2023 3:06 pm

		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	39,832	20,531	60,363	60,363	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	404,236	268,462	672,698	13,850	5.00
7.00	00700	OPERATION OF PLANT	0	477,514	192,598	670,112	2,360	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	50,240	20,263	70,503	0	8.00
9.00	00900	HOUSEKEEPING	0	8,515	3,434	11,949	1,948	9.00
10.00	01000	DIETARY	0	280,955	113,319	394,274	1,047	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	31,222	33,353	64,575	1,260	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	147,408	59,455	206,863	466	14.00
15.00	01500	PHARMACY	0	54,639	22,038	76,677	1,045	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	21,122	21,122	1,538	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	883,312	356,270	1,239,582	8,649	30.00
31.00	03100	INTENSIVE CARE UNIT	0	55,822	22,515	78,337	167	31.00
43.00	04300	NURSERY	0	19,869	8,014	27,883	21	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	519,523	209,541	729,064	1,845	50.00
51.00	05100	RECOVERY ROOM	0	336,209	135,605	471,814	1,648	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	83,023	33,486	116,509	153	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	397,802	160,447	558,249	4,774	54.00
60.00	06000	LABORATORY	0	131,229	52,929	184,158	2,428	60.00
65.00	06500	RESPIRATORY THERAPY	0	34,534	13,929	48,463	1,747	65.00
65.01	06501	SLEEP LAB	0	0	49,609	49,609	65	65.01
66.00	06600	PHYSICAL THERAPY	0	298,600	120,436	419,036	2,471	66.00
69.00	06900	ELECTROCARDIOLOGY	0	17,835	7,193	25,028	239	69.00
69.01	06901	CARDIAC REHABILITATION	0	29,803	12,021	41,824	130	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	CHEMICAL DEPENDENCY	0	0	0	0	0	76.00
76.01	03480	ONCOLOGY	0	0	211,793	211,793	0	76.01
76.02	03030	DIABETIC EDUCATION	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	129,537	129,537	840	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	124,576	124,576	1,434	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	66,705	66,705	460	88.02
90.00	09000	CLINIC	0	18,923	15,856	34,779	230	90.00
90.01	09001	CLINIC- ORTHO	0	0	75,864	75,864	361	90.01
90.02	09002	CLINIC - PEDS ENT FP	0	0	114,101	114,101	538	90.02
90.03	09003	INTRAVENOUS THERAPY	0	56,768	22,897	79,665	192	90.03
90.04	09004	PSYCHIATRY	0	0	33,715	33,715	332	90.04
90.05	09005	CARDIOLOGY	0	0	28,086	28,086	797	90.05
91.00	09100	EMERGENCY	0	451,496	182,104	633,600	5,162	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	4,829,309	2,941,804	7,771,113	58,197	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	27,438	11,067	38,505	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	1,927	1,927	0	192.00
194.00	07950	DAYCARE-INFANT/TODDLER	0	0	0	0	0	194.00
194.01	07951	MOB	0	0	0	0	0	194.01
194.02	07952	COMMUNITY HEALTH	0	0	0	0	136	194.02
194.03	07953	ASSISTED LIVING/CAMERON WOODS	0	0	0	0	0	194.03
194.04	07954	EDUCATION	0	0	0	0	0	194.04
194.05	07955	MARKETING	0	0	19,405	19,405	169	194.05
194.06	07956	GUEST MEALS	0	0	0	0	55	194.06
194.07	07957	OUTSIDE LAUNDRY	0	0	0	0	0	194.07
194.08	07958	CANCER CENTER	0	0	0	0	0	194.08
194.09	07959	URGENT CARE	0	0	0	0	0	194.09
194.10	07960	RHC	0	0	0	0	0	194.10
194.11	07961	OBGYN	0	0	0	0	0	194.11
194.12	07962	TRINE STUDENT HEALTH	0	0	0	0	287	194.12

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1315 | Period: From 10/01/2021 To 09/30/2022 | Worksheet B Part II Date/Time Prepared: 2/22/2023 3:06 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	2A	4.00	
194.13	07963	OCCUPATIONAL HEALTH	0	0	16,161	16,161	423	194.13
194.14	07964	IMMUNIZATION CLINIC	0	0	0	0	0	194.14
194.15	07965	FOUNDATION	0	6,244	4,427	10,671	307	194.15
194.16	07967	CAMERON FAMILY MEDICINE - NORTH	0	0	0	0	433	194.16
194.17	07966	CAMERON FAMILY MEDICINE - FREMONT	0	0	0	0	356	194.17
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	4,862,991	2,994,791	7,857,782	60,363	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1315 | Period: From 10/01/2021 To 09/30/2022 | Worksheet B Part II | Date/Time Prepared: 2/22/2023 3:06 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	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	686,548					5.00
7.00	00700	OPERATION OF PLANT	60,666	733,138				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,664	9,345	82,512			8.00
9.00	00900	HOUSEKEEPING	18,259	1,584	0	33,740		9.00
10.00	01000	DIETARY	13,712	52,260	0	1,243	462,536	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	10,888	5,808	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	7,472	27,419	0	116	0	14.00
15.00	01500	PHARMACY	12,626	10,163	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	13,052	0	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	83,384	164,304	76,190	11,064	453,946	30.00
31.00	03100	INTENSIVE CARE UNIT	2,115	10,383	1,442	348	8,590	31.00
43.00	04300	NURSERY	506	3,696	3,815	2,312	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	27,649	96,636	0	4,176	0	50.00
51.00	05100	RECOVERY ROOM	16,212	62,538	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,433	15,443	1,065	465	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	50,693	73,995	0	2,091	0	54.00
60.00	06000	LABORATORY	42,053	24,410	0	1,255	0	60.00
65.00	06500	RESPIRATORY THERAPY	17,167	6,424	0	290	0	65.00
65.01	06501	SLEEP LAB	1,390	0	0	93	0	65.01
66.00	06600	PHYSICAL THERAPY	21,909	55,542	0	1,016	0	66.00
69.00	06900	ELECTROCARDIOLOGY	2,170	3,317	0	0	0	69.00
69.01	06901	CARDIAC REHABILITATION	1,401	5,544	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	9,548	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	16,657	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	22,527	0	0	128	0	73.00
76.00	03020	CHEMICAL DEPENDENCY	0	0	0	0	0	76.00
76.01	03480	ONCOLOGY	23,347	0	0	17	0	76.01
76.02	03030	DIABETIC EDUCATION	902	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	17,371	0	0	273	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	25,729	0	0	6	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	15,098	0	0	35	0	88.02
90.00	09000	CLINIC	2,106	3,520	0	157	0	90.00
90.01	09001	CLINIC- ORTHO	3,886	0	0	1,057	0	90.01
90.02	09002	CLINIC - PEDS ENT FP	9,242	0	0	1,051	0	90.02
90.03	09003	INTRAVENOUS THERAPY	29,687	10,559	0	0	0	90.03
90.04	09004	PSYCHIATRY	4,106	0	0	0	0	90.04
90.05	09005	CARDIOLOGY	7,349	0	0	465	0	90.05
91.00	09100	EMERGENCY	45,783	83,982	0	5,948	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	641,759	726,872	82,512	33,606	462,536	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	408	5,104	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	20	0	0	0	0	192.00
194.00	07950	DAYCARE-INFANT/TODDLER	0	0	0	0	0	194.00
194.01	07951	MOB	0	0	0	0	0	194.01
194.02	07952	COMMUNITY HEALTH	1,212	0	0	0	0	194.02
194.03	07953	ASSISTED LIVING/CAMERON WOODS	0	0	0	0	0	194.03
194.04	07954	EDUCATION	0	0	0	0	0	194.04
194.05	07955	MARKETING	9,499	0	0	0	0	194.05
194.06	07956	GUEST MEALS	652	0	0	0	0	194.06
194.07	07957	OUTSIDE LAUNDRY	0	0	0	0	0	194.07
194.08	07958	CANCER CENTER	0	0	0	0	0	194.08
194.09	07959	URGENT CARE	0	0	0	0	0	194.09
194.10	07960	RHC	0	0	0	0	0	194.10
194.11	07961	OBGYN	0	0	0	0	0	194.11
194.12	07962	TRINE STUDENT HEALTH	2,012	0	0	0	0	194.12
194.13	07963	OCCUPATIONAL HEALTH	6,118	0	0	0	0	194.13
194.14	07964	IMMUNIZATION CLINIC	0	0	0	0	0	194.14
194.15	07965	FOUNDATION	3,932	1,162	0	0	0	194.15
194.16	07967	CAMERON FAMILY MEDICINE - NORTH	12,106	0	0	134	0	194.16

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1315 | Period: From 10/01/2021 To 09/30/2022 | Worksheet B Part II Date/Time Prepared: 2/22/2023 3:06 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
194.17	07966	CAMERON FAMILY MEDICINE - FREMONT	8,830	0	0	0	0	194.17
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)	686,548	733,138	82,512	33,740	462,536	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1315 | Period: From 10/01/2021 To 09/30/2022 | Worksheet B Part II | Date/Time Prepared: 2/22/2023 3:06 pm

		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
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	0					11.00
13.00	01300	NURSING ADMINISTRATION	0	82,531				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	242,336			14.00
15.00	01500	PHARMACY	0	0	1,618	102,129		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	78	0	35,790	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	29,560	20,830	0	392	30.00
31.00	03100	INTENSIVE CARE UNIT	0	564	0	0	5	31.00
43.00	04300	NURSERY	0	0	0	0	40	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	6,421	31,384	0	446	50.00
51.00	05100	RECOVERY ROOM	0	5,640	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	517	0	0	41	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	7,615	0	5,000	54.00
60.00	06000	LABORATORY	0	0	385	0	7,784	60.00
65.00	06500	RESPIRATORY THERAPY	0	7,026	3,453	0	1,150	65.00
65.01	06501	SLEEP LAB	0	0	0	0	23	65.01
66.00	06600	PHYSICAL THERAPY	0	9,851	947	0	1,933	66.00
69.00	06900	ELECTROCARDIOLOGY	0	376	244	0	1,332	69.00
69.01	06901	CARDIAC REHABILITATION	0	728	110	0	527	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	1,756	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	128,477	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	46,132	0	73.00
76.00	03020	CHEMICAL DEPENDENCY	0	0	0	0	0	76.00
76.01	03480	ONCOLOGY	0	0	0	0	705	76.01
76.02	03030	DIABETIC EDUCATION	0	0	16	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	1,933	0	1,689	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	14,366	0	3,438	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	1,004	0	1,144	88.02
90.00	09000	CLINIC	0	832	1,319	0	644	90.00
90.01	09001	CLINIC- ORTHO	0	0	1,052	0	655	90.01
90.02	09002	CLINIC - PEDS ENT FP	0	0	1,098	0	1,553	90.02
90.03	09003	INTRAVENOUS THERAPY	0	691	1,270	55,997	388	90.03
90.04	09004	PSYCHIATRY	0	0	99	0	807	90.04
90.05	09005	CARDIOLOGY	0	2,807	138	0	312	90.05
91.00	09100	EMERGENCY	0	17,518	19,611	0	3,199	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	82,531	238,803	102,129	33,207	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	0	0	0	0	192.00
194.00	07950	DAYCARE-INFANT/TODDLER	0	0	0	0	0	194.00
194.01	07951	MOB	0	0	0	0	0	194.01
194.02	07952	COMMUNITY HEALTH	0	0	12	0	0	194.02
194.03	07953	ASSISTED LIVING/CAMERON WOODS	0	0	0	0	0	194.03
194.04	07954	EDUCATION	0	0	0	0	0	194.04
194.05	07955	MARKETING	0	0	8	0	0	194.05
194.06	07956	GUEST MEALS	0	0	0	0	0	194.06
194.07	07957	OUTSIDE LAUNDRY	0	0	0	0	0	194.07
194.08	07958	CANCER CENTER	0	0	0	0	0	194.08
194.09	07959	URGENT CARE	0	0	0	0	0	194.09
194.10	07960	RHC	0	0	0	0	0	194.10
194.11	07961	OBGYN	0	0	0	0	0	194.11
194.12	07962	TRINE STUDENT HEALTH	0	0	276	0	450	194.12
194.13	07963	OCCUPATIONAL HEALTH	0	0	377	0	0	194.13
194.14	07964	IMMUNIZATION CLINIC	0	0	0	0	0	194.14
194.15	07965	FOUNDATION	0	0	52	0	0	194.15

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1315 | Period: From 10/01/2021 To 09/30/2022 | Worksheet B Part II Date/Time Prepared: 2/22/2023 3:06 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
194.16	07967	CAMERON FAMILY MEDICINE - NORTH	0	0	1,742	0	1,438	194.16
194.17	07966	CAMERON FAMILY MEDICINE - FREMONT	0	0	1,066	0	695	194.17
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)	0	82,531	242,336	102,129	35,790	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1315 | Period: From 10/01/2021 To 09/30/2022 | Worksheet B Part II | Date/Time Prepared: 2/22/2023 3:06 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			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
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	2,087,901	0	2,087,901		30.00
31.00	03100	INTENSIVE CARE UNIT	101,951	0	101,951		31.00
43.00	04300	NURSERY	38,273	0	38,273		43.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	897,621	0	897,621		50.00
51.00	05100	RECOVERY ROOM	557,852	0	557,852		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	136,626	0	136,626		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	702,417	0	702,417		54.00
60.00	06000	LABORATORY	262,473	0	262,473		60.00
65.00	06500	RESPIRATORY THERAPY	85,720	0	85,720		65.00
65.01	06501	SLEEP LAB	51,180	0	51,180		65.01
66.00	06600	PHYSICAL THERAPY	512,705	0	512,705		66.00
69.00	06900	ELECTROCARDIOLOGY	32,706	0	32,706		69.00
69.01	06901	CARDIAC REHABILITATION	50,264	0	50,264		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	11,304	0	11,304		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	145,134	0	145,134		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	68,787	0	68,787		73.00
76.00	03020	CHEMICAL DEPENDENCY	0	0	0		76.00
76.01	03480	ONCOLOGY	235,862	0	235,862		76.01
76.02	03030	DIABETIC EDUCATION	918	0	918		76.02
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	151,643	0	151,643		88.00
88.01	08801	RURAL HEALTH CLINIC II	169,549	0	169,549		88.01
88.02	08802	RURAL HEALTH CLINIC III	84,446	0	84,446		88.02
90.00	09000	CLINIC	43,587	0	43,587		90.00
90.01	09001	CLINIC- ORTHO	82,875	0	82,875		90.01
90.02	09002	CLINIC - PEDS ENT FP	127,583	0	127,583		90.02
90.03	09003	INTRAVENOUS THERAPY	178,449	0	178,449		90.03
90.04	09004	PSYCHIATRY	39,059	0	39,059		90.04
90.05	09005	CARDIOLOGY	39,954	0	39,954		90.05
91.00	09100	EMERGENCY	814,803	0	814,803		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	0	0	0		101.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
114.00	11400	UTILIZATION REVIEW-SNF					114.00
116.00	11600	HOSPICE	0	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	7,711,642	0	7,711,642		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	44,017	0	44,017		190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	1,947	0	1,947		192.00
194.00	07950	DAYCARE-INFANT/TODDLER	0	0	0		194.00
194.01	07951	MOB	0	0	0		194.01
194.02	07952	COMMUNITY HEALTH	1,360	0	1,360		194.02
194.03	07953	ASSISTED LIVING/CAMERON WOODS	0	0	0		194.03
194.04	07954	EDUCATION	0	0	0		194.04
194.05	07955	MARKETING	29,081	0	29,081		194.05
194.06	07956	GUEST MEALS	707	0	707		194.06
194.07	07957	OUTSIDE LAUNDRY	0	0	0		194.07
194.08	07958	CANCER CENTER	0	0	0		194.08
194.09	07959	URGENT CARE	0	0	0		194.09
194.10	07960	RHC	0	0	0		194.10
194.11	07961	OBGYN	0	0	0		194.11
194.12	07962	TRINE STUDENT HEALTH	3,025	0	3,025		194.12
194.13	07963	OCCUPATIONAL HEALTH	23,079	0	23,079		194.13

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1315 | Period: From 10/01/2021 To 09/30/2022 | Worksheet B Part II Date/Time Prepared: 2/22/2023 3:06 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
194.14	07964	IMMUNIZATION CLINIC	0	0	0		194.14
194.15	07965	FOUNDATION	16,124	0	16,124		194.15
194.16	07967	CAMERON FAMILY MEDICINE - NORTH	15,853	0	15,853		194.16
194.17	07966	CAMERON FAMILY MEDICINE - FREMONT	10,947	0	10,947		194.17
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	7,857,782	0	7,857,782		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1315 | Period: From 10/01/2021 To 09/30/2022 | Worksheet B-1 | Date/Time Prepared: 2/22/2023 3:06 pm

		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)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	102,797					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		156,956				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	842	1,076	28,647,274			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	8,545	14,070	6,571,112	-14,522,548	64,739,992	5.00
7.00	00700	OPERATION OF PLANT	10,094	10,094	1,120,084	0	5,720,494	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,062	1,062	0	0	251,192	8.00
9.00	00900	HOUSEKEEPING	180	180	924,700	0	1,721,696	9.00
10.00	01000	DIETARY	5,939	5,939	496,829	0	1,293,004	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	660	1,748	597,961	0	1,026,724	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,116	3,116	221,337	0	704,552	14.00
15.00	01500	PHARMACY	1,155	1,155	495,971	0	1,190,561	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,107	729,925	0	1,230,750	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	18,672	18,672	4,104,962	0	7,864,520	30.00
31.00	03100	INTENSIVE CARE UNIT	1,180	1,180	79,191	0	199,475	31.00
43.00	04300	NURSERY	420	420	10,166	0	47,714	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,982	10,982	875,599	0	2,607,138	50.00
51.00	05100	RECOVERY ROOM	7,107	7,107	782,325	0	1,528,745	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,755	1,755	72,554	0	229,433	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,409	8,409	2,265,781	0	4,780,077	54.00
60.00	06000	LABORATORY	2,774	2,774	1,152,331	0	3,965,350	60.00
65.00	06500	RESPIRATORY THERAPY	730	730	829,126	0	1,618,731	65.00
65.01	06501	SLEEP LAB	0	2,600	30,831	0	131,097	65.01
66.00	06600	PHYSICAL THERAPY	6,312	6,312	1,172,707	0	2,065,866	66.00
69.00	06900	ELECTROCARDIOLOGY	377	377	113,658	0	204,621	69.00
69.01	06901	CARDIAC REHABILITATION	630	630	61,777	0	132,097	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	900,343	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	1,570,686	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	2,124,164	73.00
76.00	03020	CHEMICAL DEPENDENCY	0	0	0	0	0	76.00
76.01	03480	ONCOLOGY	0	11,100	0	0	2,201,510	76.01
76.02	03030	DIABETIC EDUCATION	0	0	0	0	85,051	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	6,789	398,559	0	1,637,977	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	6,529	680,795	0	2,426,097	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	3,496	218,524	0	1,423,700	88.02
90.00	09000	CLINIC	400	831	109,090	0	198,599	90.00
90.01	09001	CLINIC- ORTHO	0	3,976	171,153	0	366,453	90.01
90.02	09002	CLINIC - PEDS ENT FP	0	5,980	255,403	0	871,500	90.02
90.03	09003	INTRAVENOUS THERAPY	1,200	1,200	91,327	0	2,799,331	90.03
90.04	09004	PSYCHIATRY	0	1,767	157,390	0	387,156	90.04
90.05	09005	CARDIOLOGY	0	1,472	378,139	0	692,979	90.05
91.00	09100	EMERGENCY	9,544	9,544	2,449,765	0	4,317,142	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	102,085	154,179	27,619,072	-14,522,548	60,516,525	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	580	580	0	0	38,505	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	101	0	0	1,927	192.00
194.00	07950	DAYCARE-INFANT/TODDLER	0	0	0	0	0	194.00
194.01	07951	MOB	0	0	0	0	0	194.01
194.02	07952	COMMUNITY HEALTH	0	0	64,400	0	114,265	194.02
194.03	07953	ASSISTED LIVING/CAMERON WOODS	0	0	0	0	0	194.03
194.04	07954	EDUCATION	0	0	0	0	0	194.04
194.05	07955	MARKETING	0	1,017	80,430	0	895,730	194.05
194.06	07956	GUEST MEALS	0	0	26,149	0	61,459	194.06
194.07	07957	OUTSIDE LAUNDRY	0	0	0	0	0	194.07
194.08	07958	CANCER CENTER	0	0	0	0	0	194.08
194.09	07959	URGENT CARE	0	0	0	0	0	194.09
194.10	07960	RHC	0	0	0	0	0	194.10
194.11	07961	OBGYN	0	0	0	0	0	194.11

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1315 | Period: From 10/01/2021 To 09/30/2022 | Worksheet B-1 | Date/Time Prepared: 2/22/2023 3:06 pm

		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	
194.12	07962	TRINE STUDENT HEALTH	0	0	136,310	0	189,710	194.12
194.13	07963	OCCUPATIONAL HEALTH	0	847	200,951	0	576,880	194.13
194.14	07964	IMMUNIZATION CLINIC	0	0	0	0	0	194.14
194.15	07965	FOUNDATION	132	232	145,624	0	370,805	194.15
194.16	07967	CAMERON FAMILY MEDICINE - NORTH	0	0	205,499	0	1,141,517	194.16
194.17	07966	CAMERON FAMILY MEDICINE - FREMONT	0	0	168,839	0	832,669	194.17
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)	4,862,991	2,994,791	10,055,552		14,522,548	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	47.306740	19.080449	0.351013		0.224321	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			60,363		686,548	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.002107		0.010605	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: 15-1315 | Period: From 10/01/2021 To 09/30/2022 | Worksheet B-1 | Date/Time Prepared: 2/22/2023 3:06 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	HOUSEKEEPING (HOURS OF SERVIC)	DIETARY (PATIENT DAYS)	CAFETERIA (FTES)	
			7.00	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
7.00	00700	OPERATION OF PLANT	83,316					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,062	7,440				8.00
9.00	00900	HOUSEKEEPING	180	0	5,809			9.00
10.00	01000	DIETARY	5,939	0	214	7,000		10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	660	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,116	0	20	0	0	14.00
15.00	01500	PHARMACY	1,155	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	18,672	6,870	1,905	6,870	0	30.00
31.00	03100	INTENSIVE CARE UNIT	1,180	130	60	130	0	31.00
43.00	04300	NURSERY	420	344	398	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,982	0	719	0	0	50.00
51.00	05100	RECOVERY ROOM	7,107	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,755	96	80	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,409	0	360	0	0	54.00
60.00	06000	LABORATORY	2,774	0	216	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	730	0	50	0	0	65.00
65.01	06501	SLEEP LAB	0	0	16	0	0	65.01
66.00	06600	PHYSICAL THERAPY	6,312	0	175	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	377	0	0	0	0	69.00
69.01	06901	CARDIAC REHABILITATION	630	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	22	0	0	73.00
76.00	03020	CHEMICAL DEPENDENCY	0	0	0	0	0	76.00
76.01	03480	ONCOLOGY	0	0	3	0	0	76.01
76.02	03030	DIABETIC EDUCATION	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	47	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	1	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	6	0	0	88.02
90.00	09000	CLINIC	400	0	27	0	0	90.00
90.01	09001	CLINIC- ORTHO	0	0	182	0	0	90.01
90.02	09002	CLINIC - PEDS ENT FP	0	0	181	0	0	90.02
90.03	09003	INTRAVENOUS THERAPY	1,200	0	0	0	0	90.03
90.04	09004	PSYCHIATRY	0	0	0	0	0	90.04
90.05	09005	CARDIOLOGY	0	0	80	0	0	90.05
91.00	09100	EMERGENCY	9,544	0	1,024	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	82,604	7,440	5,786	7,000	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	580	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	DAYCARE-INFANT/TODDLER	0	0	0	0	0	194.00
194.01	07951	MOB	0	0	0	0	0	194.01
194.02	07952	COMMUNITY HEALTH	0	0	0	0	0	194.02
194.03	07953	ASSISTED LIVING/CAMERON WOODS	0	0	0	0	0	194.03
194.04	07954	EDUCATION	0	0	0	0	0	194.04
194.05	07955	MARKETING	0	0	0	0	0	194.05
194.06	07956	GUEST MEALS	0	0	0	0	0	194.06
194.07	07957	OUTSIDE LAUNDRY	0	0	0	0	0	194.07
194.08	07958	CANCER CENTER	0	0	0	0	0	194.08
194.09	07959	URGENT CARE	0	0	0	0	0	194.09
194.10	07960	RHC	0	0	0	0	0	194.10
194.11	07961	OBGYN	0	0	0	0	0	194.11
194.12	07962	TRINE STUDENT HEALTH	0	0	0	0	0	194.12
194.13	07963	OCCUPATIONAL HEALTH	0	0	0	0	0	194.13
194.14	07964	IMMUNIZATION CLINIC	0	0	0	0	0	194.14

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1315 | Period: From 10/01/2021 To 09/30/2022 | Worksheet B-1 | Date/Time Prepared: 2/22/2023 3:06 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	HOUSEKEEPING (HOURS OF S ERVIC)	DIETARY (PATIENT DAYS)	CAFETERIA (FTES)	
			7.00	8.00	9.00	10.00	11.00	
194.15	07965	FOUNDATION	132	0	0	0	0	194.15
194.16	07967	CAMERON FAMILY MEDICINE - NORTH	0	0	23	0	0	194.16
194.17	07966	CAMERON FAMILY MEDICINE - FREMONT	0	0	0	0	0	194.17
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)	7,003,721	396,814	2,123,040	2,160,508	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	84.062137	53.335215	365.474264	308.644000	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	733,138	82,512	33,740	462,536	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	8.799486	11.090323	5.808229	66.076571	0.000000	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: 15-1315 | Period: From 10/01/2021 To 09/30/2022 | Worksheet B-1 | Date/Time Prepared: 2/22/2023 3:06 pm

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NRS ING HR)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)		
			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
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	273,924					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	2,962,670				14.00
15.00	01500	PHARMACY	0	19,785	10,000			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	955	0	730,386		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	98,112	254,657	0	7,996		30.00
31.00	03100	INTENSIVE CARE UNIT	1,872	0	0	102		31.00
43.00	04300	NURSERY	0	0	0	807		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	21,310	383,685	0	9,102		50.00
51.00	05100	RECOVERY ROOM	18,720	0	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,715	0	0	829		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	93,100	0	102,033		54.00
60.00	06000	LABORATORY	0	4,701	0	158,858		60.00
65.00	06500	RESPIRATORY THERAPY	23,320	42,215	0	23,476		65.00
65.01	06501	SLEEP LAB	0	0	0	462		65.01
66.00	06600	PHYSICAL THERAPY	32,695	11,578	0	39,455		66.00
69.00	06900	ELECTROCARDIOLOGY	1,248	2,980	0	27,186		69.00
69.01	06901	CARDIAC REHABILITATION	2,417	1,347	0	10,749		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	21,467	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,570,686	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	4,517	0		73.00
76.00	03020	CHEMICAL DEPENDENCY	0	0	0	0		76.00
76.01	03480	ONCOLOGY	0	0	0	14,396		76.01
76.02	03030	DIABETIC EDUCATION	0	190	0	0		76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	23,636	0	34,469		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	175,632	0	70,171		88.01
88.02	08802	RURAL HEALTH CLINIC III	0	12,279	0	23,349		88.02
90.00	09000	CLINIC	2,763	16,130	0	13,138		90.00
90.01	09001	CLINIC- ORTHO	0	12,858	0	13,367		90.01
90.02	09002	CLINIC - PEDS ENT FP	0	13,418	0	31,691		90.02
90.03	09003	INTRAVENOUS THERAPY	2,292	15,532	5,483	7,924		90.03
90.04	09004	PSYCHIATRY	0	1,206	0	16,473		90.04
90.05	09005	CARDIOLOGY	9,316	1,687	0	6,360		90.05
91.00	09100	EMERGENCY	58,144	239,760	0	65,284		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0		101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	0	0	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	273,924	2,919,484	10,000	677,677		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0		190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0		192.00
194.00	07950	DAYCARE-INFANT/TODDLER	0	0	0	0		194.00
194.01	07951	MOB	0	0	0	0		194.01
194.02	07952	COMMUNITY HEALTH	0	149	0	0		194.02
194.03	07953	ASSISTED LIVING/CAMERON WOODS	0	0	0	0		194.03
194.04	07954	EDUCATION	0	0	0	0		194.04
194.05	07955	MARKETING	0	100	0	0		194.05
194.06	07956	GUEST MEALS	0	0	0	0		194.06
194.07	07957	OUTSIDE LAUNDRY	0	0	0	0		194.07
194.08	07958	CANCER CENTER	0	0	0	0		194.08
194.09	07959	URGENT CARE	0	0	0	0		194.09
194.10	07960	RHC	0	0	0	0		194.10
194.11	07961	OBGYN	0	0	0	0		194.11
194.12	07962	TRINE STUDENT HEALTH	0	3,372	0	9,178		194.12
194.13	07963	OCCUPATIONAL HEALTH	0	4,611	0	0		194.13

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1315 | Period: From 10/01/2021 To 09/30/2022 | Worksheet B-1 | Date/Time Prepared: 2/22/2023 3:06 pm

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NRS ING HR)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)		
			13.00	14.00	15.00	16.00		
194.14	07964	IMMUNIZATION CLINIC	0	0	0	0		194.14
194.15	07965	FOUNDATION	0	630	0	0		194.15
194.16	07967	CAMERON FAMILY MEDICINE - NORTH	0	21,297	0	29,349		194.16
194.17	07966	CAMERON FAMILY MEDICINE - FREMONT	0	13,027	0	14,182		194.17
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)	1,312,521	1,131,845	1,562,280	1,507,198		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	4.791552	0.382035	156.228000	2.063564		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	82,531	242,336	102,129	35,790		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.301292	0.081796	10.212900	0.049001		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: 15-1315 | Period: From 10/01/2021 To 09/30/2022 | Worksheet C Part I Date/Time Prepared: 2/22/2023 3:06 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	14,965,234		14,965,234	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	421,580		421,580	0	0	31.00
43.00	04300	NURSERY	259,194		259,194	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,645,392		4,645,392	0	0	50.00
51.00	05100	RECOVERY ROOM	2,558,803		2,558,803	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	472,716		472,716	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,936,918		6,936,918	0	0	54.00
60.00	06000	LABORATORY	5,496,602		5,496,602	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	2,237,796	0	2,237,796	0	0	65.00
65.01	06501	SLEEP LAB	167,306	0	167,306	0	0	65.01
66.00	06600	PHYSICAL THERAPY	3,366,342	0	3,366,342	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	345,431		345,431	0	0	69.00
69.01	06901	CARDIAC REHABILITATION	248,965		248,965	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,110,510		1,110,510	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,523,081		2,523,081	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,314,381		3,314,381	0	0	73.00
76.00	03020	CHEMICAL DEPENDENCY	0		0	0	0	76.00
76.01	03480	ONCOLOGY	2,726,158		2,726,158	0	0	76.01
76.02	03030	DIABETIC EDUCATION	104,203		104,203	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,102,746		2,102,746	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	3,182,587		3,182,587	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	1,798,132		1,798,132	0	0	88.02
90.00	09000	CLINIC	333,154		333,154	0	0	90.00
90.01	09001	CLINIC- ORTHO	547,668		547,668	0	0	90.01
90.02	09002	CLINIC - PEDS ENT FP	1,203,669		1,203,669	0	0	90.02
90.03	09003	INTRAVENOUS THERAPY	4,418,021		4,418,021	0	0	90.03
90.04	09004	PSYCHIATRY	508,457		508,457	0	0	90.04
90.05	09005	CARDIOLOGY	936,073		936,073	0	0	90.05
91.00	09100	EMERGENCY	6,967,018		6,967,018	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	4,005,824		4,005,824		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	0		0		0	116.00
200.00		Subtotal (see instructions)	77,903,961	0	77,903,961	0	0	200.00
201.00		Less Observation Beds	4,005,824		4,005,824		0	201.00
202.00		Total (see instructions)	73,898,137	0	73,898,137	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1315 | Period: From 10/01/2021 To 09/30/2022 | Worksheet C Part I Date/Time Prepared: 2/22/2023 3:06 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,920,860		11,920,860			30.00
31.00	03100	INTENSIVE CARE UNIT	393,000		393,000			31.00
43.00	04300	NURSERY	340,000		340,000			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,791,339	12,430,402	14,221,741	0.326640	0.000000	50.00
51.00	05100	RECOVERY ROOM	945,664	5,403,943	6,349,607	0.402986	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,113,200	20,289	1,133,489	0.417045	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,414,241	45,728,674	48,142,915	0.144090	0.000000	54.00
60.00	06000	LABORATORY	3,820,917	25,083,966	28,904,883	0.190162	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	2,392,119	1,276,588	3,668,707	0.609969	0.000000	65.00
65.01	06501	SLEEP LAB	0	1,118,233	1,118,233	0.149616	0.000000	65.01
66.00	06600	PHYSICAL THERAPY	1,663,921	4,584,724	6,248,645	0.538732	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	165,573	3,135,103	3,300,676	0.104655	0.000000	69.00
69.01	06901	CARDIAC REHABILITATION	0	539,342	539,342	0.461609	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	881,067	6,848,157	7,729,224	0.143677	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	336,600	2,476,530	2,813,130	0.896895	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,350,969	7,104,061	10,455,030	0.317013	0.000000	73.00
76.00	03020	CHEMICAL DEPENDENCY	0	0	0	0.000000	0.000000	76.00
76.01	03480	ONCOLOGY	0	21,506,696	21,506,696	0.126759	0.000000	76.01
76.02	03030	DIABETIC EDUCATION	6,500	57,504	64,004	1.628070	0.000000	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	10,672	2,169,275	2,179,947			88.00
88.01	08801	RURAL HEALTH CLINIC II	0	3,729,278	3,729,278			88.01
88.02	08802	RURAL HEALTH CLINIC III	740,113	1,255,961	1,996,074			88.02
90.00	09000	CLINIC	0	542,397	542,397	0.614225	0.000000	90.00
90.01	09001	CLINIC- ORTHO	0	31,487	31,487	17.393464	0.000000	90.01
90.02	09002	CLINIC - PEDS ENT FP	0	567,986	567,986	2.119188	0.000000	90.02
90.03	09003	INTRAVENOUS THERAPY	0	8,775,477	8,775,477	0.503451	0.000000	90.03
90.04	09004	PSYCHIATRY	0	251,879	251,879	2.018656	0.000000	90.04
90.05	09005	CARDIOLOGY	0	28,951	28,951	32.333011	0.000000	90.05
91.00	09100	EMERGENCY	916,462	30,665,969	31,582,431	0.220598	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	107,728	2,767,521	2,875,249	1.393209	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	0	0	0			116.00
200.00		Subtotal (see instructions)	33,310,945	188,100,393	221,411,338			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	33,310,945	188,100,393	221,411,338			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1315 | Period: From 10/01/2021 To 09/30/2022 | Worksheet C Part I Date/Time Prepared: 2/22/2023 3:06 pm

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
51.00	05100	RECOVERY ROOM	0.000000		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
65.01	06501	SLEEP LAB	0.000000		65.01
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
69.01	06901	CARDIAC REHABILITATION	0.000000		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03020	CHEMICAL DEPENDENCY	0.000000		76.00
76.01	03480	ONCOLOGY	0.000000		76.01
76.02	03030	DIABETIC EDUCATION	0.000000		76.02
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC			88.00
88.01	08801	RURAL HEALTH CLINIC II			88.01
88.02	08802	RURAL HEALTH CLINIC III			88.02
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	CLINIC- ORTHO	0.000000		90.01
90.02	09002	CLINIC - PEDS ENT FP	0.000000		90.02
90.03	09003	INTRAVENOUS THERAPY	0.000000		90.03
90.04	09004	PSYCHIATRY	0.000000		90.04
90.05	09005	CARDIOLOGY	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			
101.00	10100	HOME HEALTH AGENCY			101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
114.00	11400	UTILIZATION REVIEW-SNF			114.00
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: 15-1315 | Period: From 10/01/2021 To 09/30/2022 | Worksheet C Part I Date/Time Prepared: 2/22/2023 3:06 pm

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	14,965,234		14,965,234	0	14,965,234	30.00
31.00	03100	INTENSIVE CARE UNIT	421,580		421,580	0	421,580	31.00
43.00	04300	NURSERY	259,194		259,194	0	259,194	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,645,392		4,645,392	0	4,645,392	50.00
51.00	05100	RECOVERY ROOM	2,558,803		2,558,803	0	2,558,803	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	472,716		472,716	0	472,716	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,936,918		6,936,918	0	6,936,918	54.00
60.00	06000	LABORATORY	5,496,602		5,496,602	0	5,496,602	60.00
65.00	06500	RESPIRATORY THERAPY	2,237,796	0	2,237,796	0	2,237,796	65.00
65.01	06501	SLEEP LAB	167,306	0	167,306	0	167,306	65.01
66.00	06600	PHYSICAL THERAPY	3,366,342	0	3,366,342	0	3,366,342	66.00
69.00	06900	ELECTROCARDIOLOGY	345,431		345,431	0	345,431	69.00
69.01	06901	CARDIAC REHABILITATION	248,965		248,965	0	248,965	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,110,510		1,110,510	0	1,110,510	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,523,081		2,523,081	0	2,523,081	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,314,381		3,314,381	0	3,314,381	73.00
76.00	03020	CHEMICAL DEPENDENCY	0		0	0	0	76.00
76.01	03480	ONCOLOGY	2,726,158		2,726,158	0	2,726,158	76.01
76.02	03030	DIABETIC EDUCATION	104,203		104,203	0	104,203	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,102,746		2,102,746	0	2,102,746	88.00
88.01	08801	RURAL HEALTH CLINIC II	3,182,587		3,182,587	0	3,182,587	88.01
88.02	08802	RURAL HEALTH CLINIC III	1,798,132		1,798,132	0	1,798,132	88.02
90.00	09000	CLINIC	333,154		333,154	0	333,154	90.00
90.01	09001	CLINIC- ORTHO	547,668		547,668	0	547,668	90.01
90.02	09002	CLINIC - PEDS ENT FP	1,203,669		1,203,669	0	1,203,669	90.02
90.03	09003	INTRAVENOUS THERAPY	4,418,021		4,418,021	0	4,418,021	90.03
90.04	09004	PSYCHIATRY	508,457		508,457	0	508,457	90.04
90.05	09005	CARDIOLOGY	936,073		936,073	0	936,073	90.05
91.00	09100	EMERGENCY	6,967,018		6,967,018	0	6,967,018	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	4,005,824		4,005,824		4,005,824	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	0		0		0	116.00
200.00		Subtotal (see instructions)	77,903,961	0	77,903,961	0	77,903,961	200.00
201.00		Less Observation Beds	4,005,824		4,005,824		4,005,824	201.00
202.00		Total (see instructions)	73,898,137	0	73,898,137	0	73,898,137	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1315 | Period: From 10/01/2021 To 09/30/2022 | Worksheet C Part I Date/Time Prepared: 2/22/2023 3:06 pm

Title XIX | 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	11,920,860		11,920,860			30.00
31.00	03100	INTENSIVE CARE UNIT	393,000		393,000			31.00
43.00	04300	NURSERY	340,000		340,000			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,791,339	12,430,402	14,221,741	0.326640	0.000000	50.00
51.00	05100	RECOVERY ROOM	945,664	5,403,943	6,349,607	0.402986	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,113,200	20,289	1,133,489	0.417045	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,414,241	45,728,674	48,142,915	0.144090	0.000000	54.00
60.00	06000	LABORATORY	3,820,917	25,083,966	28,904,883	0.190162	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	2,392,119	1,276,588	3,668,707	0.609969	0.000000	65.00
65.01	06501	SLEEP LAB	0	1,118,233	1,118,233	0.149616	0.000000	65.01
66.00	06600	PHYSICAL THERAPY	1,663,921	4,584,724	6,248,645	0.538732	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	165,573	3,135,103	3,300,676	0.104655	0.000000	69.00
69.01	06901	CARDIAC REHABILITATION	0	539,342	539,342	0.461609	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	881,067	6,848,157	7,729,224	0.143677	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	336,600	2,476,530	2,813,130	0.896895	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,350,969	7,104,061	10,455,030	0.317013	0.000000	73.00
76.00	03020	CHEMICAL DEPENDENCY	0	0	0	0.000000	0.000000	76.00
76.01	03480	ONCOLOGY	0	21,506,696	21,506,696	0.126759	0.000000	76.01
76.02	03030	DIABETIC EDUCATION	6,500	57,504	64,004	1.628070	0.000000	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	10,672	2,169,275	2,179,947	0.964586	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	3,729,278	3,729,278	0.853406	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III	740,113	1,255,961	1,996,074	0.900834	0.000000	88.02
90.00	09000	CLINIC	0	542,397	542,397	0.614225	0.000000	90.00
90.01	09001	CLINIC- ORTHO	0	31,487	31,487	17.393464	0.000000	90.01
90.02	09002	CLINIC - PEDS ENT FP	0	567,986	567,986	2.119188	0.000000	90.02
90.03	09003	INTRAVENOUS THERAPY	0	8,775,477	8,775,477	0.503451	0.000000	90.03
90.04	09004	PSYCHIATRY	0	251,879	251,879	2.018656	0.000000	90.04
90.05	09005	CARDIOLOGY	0	28,951	28,951	32.333011	0.000000	90.05
91.00	09100	EMERGENCY	916,462	30,665,969	31,582,431	0.220598	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	107,728	2,767,521	2,875,249	1.393209	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	0	0	0			116.00
200.00		Subtotal (see instructions)	33,310,945	188,100,393	221,411,338			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	33,310,945	188,100,393	221,411,338			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1315 | Period: From 10/01/2021 To 09/30/2022 | Worksheet C Part I Date/Time Prepared: 2/22/2023 3:06 pm

Title XIX | 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
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.326640		50.00
51.00	05100	RECOVERY ROOM	0.402986		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.417045		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.144090		54.00
60.00	06000	LABORATORY	0.190162		60.00
65.00	06500	RESPIRATORY THERAPY	0.609969		65.00
65.01	06501	SLEEP LAB	0.149616		65.01
66.00	06600	PHYSICAL THERAPY	0.538732		66.00
69.00	06900	ELECTROCARDIOLOGY	0.104655		69.00
69.01	06901	CARDIAC REHABILITATION	0.461609		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.143677		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.896895		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.317013		73.00
76.00	03020	CHEMICAL DEPENDENCY	0.000000		76.00
76.01	03480	ONCOLOGY	0.126759		76.01
76.02	03030	DIABETIC EDUCATION	1.628070		76.02
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0.964586		88.00
88.01	08801	RURAL HEALTH CLINIC II	0.853406		88.01
88.02	08802	RURAL HEALTH CLINIC III	0.900834		88.02
90.00	09000	CLINIC	0.614225		90.00
90.01	09001	CLINIC- ORTHO	17.393464		90.01
90.02	09002	CLINIC - PEDS ENT FP	2.119188		90.02
90.03	09003	INTRAVENOUS THERAPY	0.503451		90.03
90.04	09004	PSYCHIATRY	2.018656		90.04
90.05	09005	CARDIOLOGY	32.333011		90.05
91.00	09100	EMERGENCY	0.220598		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.393209		92.00
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY			101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
114.00	11400	UTILIZATION REVIEW-SNF			114.00
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

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY

Provider CCN: 15-1315 | Period: From 10/01/2021 To 09/30/2022 | Worksheet C Part II Date/Time Prepared: 2/22/2023 3:06 pm

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,645,392	897,621	3,747,771	0	0	50.00
51.00	05100	RECOVERY ROOM	2,558,803	557,852	2,000,951	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	472,716	136,626	336,090	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,936,918	702,417	6,234,501	0	0	54.00
60.00	06000	LABORATORY	5,496,602	262,473	5,234,129	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	2,237,796	85,720	2,152,076	0	0	65.00
65.01	06501	SLEEP LAB	167,306	51,180	116,126	0	0	65.01
66.00	06600	PHYSICAL THERAPY	3,366,342	512,705	2,853,637	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	345,431	32,706	312,725	0	0	69.00
69.01	06901	CARDIAC REHABILITATION	248,965	50,264	198,701	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,110,510	11,304	1,099,206	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,523,081	145,134	2,377,947	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,314,381	68,787	3,245,594	0	0	73.00
76.00	03020	CHEMICAL DEPENDENCY	0	0	0	0	0	76.00
76.01	03480	ONCOLOGY	2,726,158	235,862	2,490,296	0	0	76.01
76.02	03030	DIABETIC EDUCATION	104,203	918	103,285	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,102,746	151,643	1,951,103	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	3,182,587	169,549	3,013,038	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	1,798,132	84,446	1,713,686	0	0	88.02
90.00	09000	CLINIC	333,154	43,587	289,567	0	0	90.00
90.01	09001	CLINIC- ORTHO	547,668	82,875	464,793	0	0	90.01
90.02	09002	CLINIC - PEDS ENT FP	1,203,669	127,583	1,076,086	0	0	90.02
90.03	09003	INTRAVENOUS THERAPY	4,418,021	178,449	4,239,572	0	0	90.03
90.04	09004	PSYCHIATRY	508,457	39,059	469,398	0	0	90.04
90.05	09005	CARDIOLOGY	936,073	39,954	896,119	0	0	90.05
91.00	09100	EMERGENCY	6,967,018	814,803	6,152,215	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	4,005,824	558,881	3,446,943	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
200.00		Subtotal (sum of lines 50 thru 199)	62,257,953	6,042,398	56,215,555	0	0	200.00
201.00		Less Observation Beds	4,005,824	558,881	3,446,943	0	0	201.00
202.00		Total (line 200 minus line 201)	58,252,129	5,483,517	52,768,612	0	0	202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY

Provider CCN: 15-1315 | Period: From 10/01/2021 To 09/30/2022 | Worksheet C Part II Date/Time Prepared: 2/22/2023 3:06 pm

Title XIX | Hospital | PPS

		Cost Center Description	Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)		
			6.00	7.00	8.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	4,645,392	14,221,741	0.326640		50.00
51.00	05100	RECOVERY ROOM	2,558,803	6,349,607	0.402986		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	472,716	1,133,489	0.417045		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,936,918	48,142,915	0.144090		54.00
60.00	06000	LABORATORY	5,496,602	28,904,883	0.190162		60.00
65.00	06500	RESPIRATORY THERAPY	2,237,796	3,668,707	0.609969		65.00
65.01	06501	SLEEP LAB	167,306	1,118,233	0.149616		65.01
66.00	06600	PHYSICAL THERAPY	3,366,342	6,248,645	0.538732		66.00
69.00	06900	ELECTROCARDIOLOGY	345,431	3,300,676	0.104655		69.00
69.01	06901	CARDIAC REHABILITATION	248,965	539,342	0.461609		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,110,510	7,729,224	0.143677		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,523,081	2,813,130	0.896895		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,314,381	10,455,030	0.317013		73.00
76.00	03020	CHEMICAL DEPENDENCY	0	0	0.000000		76.00
76.01	03480	ONCOLOGY	2,726,158	21,506,696	0.126759		76.01
76.02	03030	DIABETIC EDUCATION	104,203	64,004	1.628070		76.02
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	2,102,746	2,179,947	0.964586		88.00
88.01	08801	RURAL HEALTH CLINIC II	3,182,587	3,729,278	0.853406		88.01
88.02	08802	RURAL HEALTH CLINIC III	1,798,132	1,996,074	0.900834		88.02
90.00	09000	CLINIC	333,154	542,397	0.614225		90.00
90.01	09001	CLINIC- ORTHO	547,668	31,487	17.393464		90.01
90.02	09002	CLINIC - PEDS ENT FP	1,203,669	567,986	2.119188		90.02
90.03	09003	INTRAVENOUS THERAPY	4,418,021	8,775,477	0.503451		90.03
90.04	09004	PSYCHIATRY	508,457	251,879	2.018656		90.04
90.05	09005	CARDIOLOGY	936,073	28,951	32.333011		90.05
91.00	09100	EMERGENCY	6,967,018	31,582,431	0.220598		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	4,005,824	2,875,249	1.393209		92.00
		OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	0	0	0.000000		101.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
114.00	11400	UTILIZATION REVIEW-SNF					114.00
116.00	11600	HOSPICE	0	0	0.000000		116.00
200.00		Subtotal (sum of lines 50 thru 199)	62,257,953	208,757,478			200.00
201.00		Less Observation Beds	4,005,824	0			201.00
202.00		Total (line 200 minus line 201)	58,252,129	208,757,478			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-1315 | Period: From 10/01/2021 To 09/30/2022 | Worksheet D Part II Date/Time Prepared: 2/22/2023 3:06 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	897,621	14,221,741	0.063116	370,481	23,383	50.00
51.00	05100	RECOVERY ROOM	557,852	6,349,607	0.087856	122,770	10,786	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	136,626	1,133,489	0.120536	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	702,417	48,142,915	0.014590	592,437	8,644	54.00
60.00	06000	LABORATORY	262,473	28,904,883	0.009081	811,712	7,371	60.00
65.00	06500	RESPIRATORY THERAPY	85,720	3,668,707	0.023365	362,791	8,477	65.00
65.01	06501	SLEEP LAB	51,180	1,118,233	0.045769	0	0	65.01
66.00	06600	PHYSICAL THERAPY	512,705	6,248,645	0.082051	243,182	19,953	66.00
69.00	06900	ELECTROCARDIOLOGY	32,706	3,300,676	0.009909	40,298	399	69.00
69.01	06901	CARDIAC REHABILITATION	50,264	539,342	0.093195	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	11,304	7,729,224	0.001463	294,469	431	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	145,134	2,813,130	0.051592	110,470	5,699	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	68,787	10,455,030	0.006579	719,664	4,735	73.00
76.00	03020	CHEMICAL DEPENDENCY	0	0	0.000000	0	0	76.00
76.01	03480	ONCOLOGY	235,862	21,506,696	0.010967	0	0	76.01
76.02	03030	DIABETIC EDUCATION	918	64,004	0.014343	6,400	92	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	151,643	2,179,947	0.069563	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	169,549	3,729,278	0.045464	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	84,446	1,996,074	0.042306	0	0	88.02
90.00	09000	CLINIC	43,587	542,397	0.080360	0	0	90.00
90.01	09001	CLINIC- ORTHO	82,875	31,487	2.632039	0	0	90.01
90.02	09002	CLINIC - PEDS ENT FP	127,583	567,986	0.224623	0	0	90.02
90.03	09003	INTRAVENOUS THERAPY	178,449	8,775,477	0.020335	0	0	90.03
90.04	09004	PSYCHIATRY	39,059	251,879	0.155070	0	0	90.04
90.05	09005	CARDIOLOGY	39,954	28,951	1.380056	0	0	90.05
91.00	09100	EMERGENCY	814,803	31,582,431	0.025799	135,004	3,483	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	558,881	2,875,249	0.194377	0	0	92.00
200.00		Total (lines 50 through 199)	6,042,398	208,757,478		3,809,678	93,453	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1315 | Period: From 10/01/2021 To 09/30/2022 | Worksheet D Part IV Date/Time Prepared: 2/22/2023 3:06 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
65.01	06501	SLEEP LAB	0	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	CARDIAC REHABILITATION	0	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	CHEMICAL DEPENDENCY	0	0	0	0	0	76.00
76.01	03480	ONCOLOGY	0	0	0	0	0	76.01
76.02	03030	DIABETIC EDUCATION	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC- ORTHO	0	0	0	0	0	90.01
90.02	09002	CLINIC - PEDS ENT FP	0	0	0	0	0	90.02
90.03	09003	INTRAVENOUS THERAPY	0	0	0	0	0	90.03
90.04	09004	PSYCHIATRY	0	0	0	0	0	90.04
90.05	09005	CARDIOLOGY	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
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: 15-1315 | Period: From 10/01/2021 To 09/30/2022 | Worksheet D Part IV | Date/Time Prepared: 2/22/2023 3:06 pm

Title XVIII | Hospital | Cost

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	14,221,741	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	6,349,607	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	1,133,489	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	48,142,915	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	28,904,883	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	3,668,707	0.000000	65.00
65.01	06501	SLEEP LAB	0	0	0	1,118,233	0.000000	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	6,248,645	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	3,300,676	0.000000	69.00
69.01	06901	CARDIAC REHABILITATION	0	0	0	539,342	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	7,729,224	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	2,813,130	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	10,455,030	0.000000	73.00
76.00	03020	CHEMICAL DEPENDENCY	0	0	0	0	0.000000	76.00
76.01	03480	ONCOLOGY	0	0	0	21,506,696	0.000000	76.01
76.02	03030	DIABETIC EDUCATION	0	0	0	64,004	0.000000	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	2,179,947	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	3,729,278	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	1,996,074	0.000000	88.02
90.00	09000	CLINIC	0	0	0	542,397	0.000000	90.00
90.01	09001	CLINIC- ORTHO	0	0	0	31,487	0.000000	90.01
90.02	09002	CLINIC - PEDS ENT FP	0	0	0	567,986	0.000000	90.02
90.03	09003	INTRAVENOUS THERAPY	0	0	0	8,775,477	0.000000	90.03
90.04	09004	PSYCHIATRY	0	0	0	251,879	0.000000	90.04
90.05	09005	CARDIOLOGY	0	0	0	28,951	0.000000	90.05
91.00	09100	EMERGENCY	0	0	0	31,582,431	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	2,875,249	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	208,757,478		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1315 | Period: From 10/01/2021 To 09/30/2022 | Worksheet D Part IV Date/Time Prepared: 2/22/2023 3:06 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	370,481	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	122,770	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	592,437	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	811,712	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	362,791	0	0	0	65.00
65.01	06501	SLEEP LAB	0.000000	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.000000	243,182	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	40,298	0	0	0	69.00
69.01	06901	CARDIAC REHABILITATION	0.000000	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	294,469	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	110,470	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	719,664	0	0	0	73.00
76.00	03020	CHEMICAL DEPENDENCY	0.000000	0	0	0	0	76.00
76.01	03480	ONCOLOGY	0.000000	0	0	0	0	76.01
76.02	03030	DIABETIC EDUCATION	0.000000	6,400	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000	0	0	0	0	88.02
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	CLINIC- ORTHO	0.000000	0	0	0	0	90.01
90.02	09002	CLINIC - PEDS ENT FP	0.000000	0	0	0	0	90.02
90.03	09003	INTRAVENOUS THERAPY	0.000000	0	0	0	0	90.03
90.04	09004	PSYCHIATRY	0.000000	0	0	0	0	90.04
90.05	09005	CARDIOLOGY	0.000000	0	0	0	0	90.05
91.00	09100	EMERGENCY	0.000000	135,004	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		3,809,678	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1315 | Period: From 10/01/2021 To 09/30/2022 | Worksheet D Part V Date/Time Prepared: 2/22/2023 3:06 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.326640	0	2,663,482	0	0	50.00
51.00	05100	RECOVERY ROOM	0.402986	0	775,720	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.417045	0	1,150	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.144090	0	10,350,488	0	0	54.00
60.00	06000	LABORATORY	0.190162	0	4,753,976	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.609969	0	228,802	0	0	65.00
65.01	06501	SLEEP LAB	0.149616	0	227,827	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.538732	0	1,126,854	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.104655	0	631,824	0	0	69.00
69.01	06901	CARDIAC REHABILITATION	0.461609	0	187,063	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.143677	0	359,313	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.896895	0	460,066	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.317013	0	2,012,940	0	0	73.00
76.00	03020	CHEMICAL DEPENDENCY	0.000000	0	0	0	0	76.00
76.01	03480	ONCOLOGY	0.126759	0	4,229,722	0	0	76.01
76.02	03030	DIABETIC EDUCATION	1.628070	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC						88.00
88.01	08801	RURAL HEALTH CLINIC II						88.01
88.02	08802	RURAL HEALTH CLINIC III						88.02
90.00	09000	CLINIC	0.614225	0	222,951	0	0	90.00
90.01	09001	CLINIC- ORTHO	17.393464	0	27,842	0	0	90.01
90.02	09002	CLINIC - PEDS ENT FP	2.119188	0	47,520	0	0	90.02
90.03	09003	INTRAVENOUS THERAPY	0.503451	0	3,579,036	7,722	0	90.03
90.04	09004	PSYCHIATRY	2.018656	0	32,674	0	0	90.04
90.05	09005	CARDIOLOGY	32.333011	0	15,592	0	0	90.05
91.00	09100	EMERGENCY	0.220598	0	4,815,512	126,997	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.393209	0	1,290,302	0	0	92.00
200.00		Subtotal (see instructions)		0	38,040,656	134,719	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	38,040,656	134,719	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1315 | Period: From 10/01/2021 To 09/30/2022 | Worksheet D Part V Date/Time Prepared: 2/22/2023 3:06 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	870,000	0		50.00
51.00	05100	RECOVERY ROOM	312,604	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	480	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,491,402	0		54.00
60.00	06000	LABORATORY	904,026	0		60.00
65.00	06500	RESPIRATORY THERAPY	139,562	0		65.00
65.01	06501	SLEEP LAB	34,087	0		65.01
66.00	06600	PHYSICAL THERAPY	607,072	0		66.00
69.00	06900	ELECTROCARDIOLOGY	66,124	0		69.00
69.01	06901	CARDIAC REHABILITATION	86,350	0		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	51,625	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	412,631	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	638,128	0		73.00
76.00	03020	CHEMICAL DEPENDENCY	0	0		76.00
76.01	03480	ONCOLOGY	536,155	0		76.01
76.02	03030	DIABETIC EDUCATION	0	0		76.02
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC				88.00
88.01	08801	RURAL HEALTH CLINIC II				88.01
88.02	08802	RURAL HEALTH CLINIC III				88.02
90.00	09000	CLINIC	136,942	0		90.00
90.01	09001	CLINIC- ORTHO	484,269	0		90.01
90.02	09002	CLINIC - PEDS ENT FP	100,704	0		90.02
90.03	09003	INTRAVENOUS THERAPY	1,801,869	3,888		90.03
90.04	09004	PSYCHIATRY	65,958	0		90.04
90.05	09005	CARDIOLOGY	504,136	0		90.05
91.00	09100	EMERGENCY	1,062,292	28,015		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,797,660	0		92.00
200.00		Subtotal (see instructions)	12,104,076	31,903		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	12,104,076	31,903		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-1315 | Period: From 10/01/2021 To 09/30/2022 | Worksheet D Part I Date/Time Prepared: 2/22/2023 3:06 pm

Title XIX | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	2,087,901	391,260	1,696,641	5,513	307.75	30.00
31.00	INTENSIVE CARE UNIT	101,951		101,951	130	784.24	31.00
43.00	NURSERY	38,273		38,273	344	111.26	43.00
200.00	Total (lines 30 through 199)	2,228,125		1,836,865	5,987		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	61	18,773	30.00
31.00	INTENSIVE CARE UNIT	4	3,137	31.00
43.00	NURSERY	13	1,446	43.00
200.00	Total (lines 30 through 199)	78	23,356	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-1315 | Period: From 10/01/2021 To 09/30/2022 | Worksheet D Part II Date/Time Prepared: 2/22/2023 3:06 pm

Title XIX | 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	897,621	14,221,741	0.063116	19,721	1,245	50.00
51.00	05100	RECOVERY ROOM	557,852	6,349,607	0.087856	10,648	935	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	136,626	1,133,489	0.120536	13,950	1,681	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	702,417	48,142,915	0.014590	52,158	761	54.00
60.00	06000	LABORATORY	262,473	28,904,883	0.009081	71,179	646	60.00
65.00	06500	RESPIRATORY THERAPY	85,720	3,668,707	0.023365	26,818	627	65.00
65.01	06501	SLEEP LAB	51,180	1,118,233	0.045769	0	0	65.01
66.00	06600	PHYSICAL THERAPY	512,705	6,248,645	0.082051	3,698	303	66.00
69.00	06900	ELECTROCARDIOLOGY	32,706	3,300,676	0.009909	3,960	39	69.00
69.01	06901	CARDIAC REHABILITATION	50,264	539,342	0.093195	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	11,304	7,729,224	0.001463	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	145,134	2,813,130	0.051592	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	68,787	10,455,030	0.006579	65,081	428	73.00
76.00	03020	CHEMICAL DEPENDENCY	0	0	0.000000	0	0	76.00
76.01	03480	ONCOLOGY	235,862	21,506,696	0.010967	0	0	76.01
76.02	03030	DIABETIC EDUCATION	918	64,004	0.014343	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	151,643	2,179,947	0.069563	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	169,549	3,729,278	0.045464	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	84,446	1,996,074	0.042306	0	0	88.02
90.00	09000	CLINIC	43,587	542,397	0.080360	0	0	90.00
90.01	09001	CLINIC- ORTHO	82,875	31,487	2.632039	0	0	90.01
90.02	09002	CLINIC - PEDS ENT FP	127,583	567,986	0.224623	0	0	90.02
90.03	09003	INTRAVENOUS THERAPY	178,449	8,775,477	0.020335	0	0	90.03
90.04	09004	PSYCHIATRY	39,059	251,879	0.155070	0	0	90.04
90.05	09005	CARDIOLOGY	39,954	28,951	1.380056	0	0	90.05
91.00	09100	EMERGENCY	814,803	31,582,431	0.025799	42,841	1,105	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	558,881	2,875,249	0.194377	0	0	92.00
200.00		Total (lines 50 through 199)	6,042,398	208,757,478		310,054	7,770	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1315 | Period: From 10/01/2021 To 09/30/2022 | Worksheet D Part III Date/Time Prepared: 2/22/2023 3:06 pm

Title XIX | Hospital | PPS

		Cost Center Description	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
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	5,513	0.00	61	30.00
31.00	03100	INTENSIVE CARE UNIT		0	130	0.00	4	31.00
43.00	04300	NURSERY		0	344	0.00	13	43.00
200.00		Total (lines 30 through 199)		0	5,987		78	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
43.00	04300	NURSERY	0	43.00
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1315 | Period: From 10/01/2021 To 09/30/2022 | Worksheet D Part IV Date/Time Prepared: 2/22/2023 3:06 pm

Title XIX | Hospital | 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
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
65.01	06501	SLEEP LAB	0	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	CARDIAC REHABILITATION	0	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	CHEMICAL DEPENDENCY	0	0	0	0	0	76.00
76.01	03480	ONCOLOGY	0	0	0	0	0	76.01
76.02	03030	DIABETIC EDUCATION	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC- ORTHO	0	0	0	0	0	90.01
90.02	09002	CLINIC - PEDS ENT FP	0	0	0	0	0	90.02
90.03	09003	INTRAVENOUS THERAPY	0	0	0	0	0	90.03
90.04	09004	PSYCHIATRY	0	0	0	0	0	90.04
90.05	09005	CARDIOLOGY	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
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: 15-1315 | Period: From 10/01/2021 To 09/30/2022 | Worksheet D Part IV | Date/Time Prepared: 2/22/2023 3:06 pm

Title XIX | Hospital | 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	14,221,741	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	6,349,607	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	1,133,489	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	48,142,915	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	28,904,883	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	3,668,707	0.000000	65.00
65.01	06501	SLEEP LAB	0	0	0	1,118,233	0.000000	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	6,248,645	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	3,300,676	0.000000	69.00
69.01	06901	CARDIAC REHABILITATION	0	0	0	539,342	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	7,729,224	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	2,813,130	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	10,455,030	0.000000	73.00
76.00	03020	CHEMICAL DEPENDENCY	0	0	0	0	0.000000	76.00
76.01	03480	ONCOLOGY	0	0	0	21,506,696	0.000000	76.01
76.02	03030	DIABETIC EDUCATION	0	0	0	64,004	0.000000	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	2,179,947	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	3,729,278	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	1,996,074	0.000000	88.02
90.00	09000	CLINIC	0	0	0	542,397	0.000000	90.00
90.01	09001	CLINIC- ORTHO	0	0	0	31,487	0.000000	90.01
90.02	09002	CLINIC - PEDS ENT FP	0	0	0	567,986	0.000000	90.02
90.03	09003	INTRAVENOUS THERAPY	0	0	0	8,775,477	0.000000	90.03
90.04	09004	PSYCHIATRY	0	0	0	251,879	0.000000	90.04
90.05	09005	CARDIOLOGY	0	0	0	28,951	0.000000	90.05
91.00	09100	EMERGENCY	0	0	0	31,582,431	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	2,875,249	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	208,757,478		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1315 | Period: From 10/01/2021 To 09/30/2022 | Worksheet D Part IV Date/Time Prepared: 2/22/2023 3:06 pm

Title XIX | Hospital | 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	19,721	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	10,648	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	13,950	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	52,158	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	71,179	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	26,818	0	0	0	65.00
65.01	06501	SLEEP LAB	0.000000	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.000000	3,698	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	3,960	0	0	0	69.00
69.01	06901	CARDIAC REHABILITATION	0.000000	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	65,081	0	0	0	73.00
76.00	03020	CHEMICAL DEPENDENCY	0.000000	0	0	0	0	76.00
76.01	03480	ONCOLOGY	0.000000	0	0	0	0	76.01
76.02	03030	DIABETIC EDUCATION	0.000000	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000	0	0	0	0	88.02
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	CLINIC- ORTHO	0.000000	0	0	0	0	90.01
90.02	09002	CLINIC - PEDS ENT FP	0.000000	0	0	0	0	90.02
90.03	09003	INTRAVENOUS THERAPY	0.000000	0	0	0	0	90.03
90.04	09004	PSYCHIATRY	0.000000	0	0	0	0	90.04
90.05	09005	CARDIOLOGY	0.000000	0	0	0	0	90.05
91.00	09100	EMERGENCY	0.000000	42,841	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		310,054	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1315 | Period: From 10/01/2021 To 09/30/2022 | Worksheet D-1 | Date/Time Prepared: 2/22/2023 3:06 pm

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	6,870	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	5,513	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)	3,697	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	219	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)	1,043	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	23	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)	72	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	1,007	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)	114	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)	438	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	216.95	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	216.95	20.00
21.00	Total general inpatient routine service cost (see instructions)	14,965,234	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)	4,990	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)	15,620	25.00
26.00	Total swing-bed cost (see instructions)	2,804,393	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	12,160,841	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)	12,160,841	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	2,205.85	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,221,291	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)	2,221,291	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1315 | Period: From 10/01/2021 To 09/30/2022 | Worksheet D-1 | Date/Time Prepared: 2/22/2023 3:06 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	421,580	130	3,242.92	36	116,745	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	1,176,461	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	3,514,497	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)	251,467	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	966,162	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	1,217,629	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	1,816	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,205.85	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	4,005,824	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1315 | Period: From 10/01/2021 To 09/30/2022 | Worksheet D-1 | Date/Time Prepared: 2/22/2023 3:06 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	2,087,901	14,965,234	0.139517	4,005,824	558,881	90.00
91.00	Nursing Program cost	0	14,965,234	0.000000	4,005,824	0	91.00
92.00	Allied health cost	0	14,965,234	0.000000	4,005,824	0	92.00
93.00	All other Medical Education	0	14,965,234	0.000000	4,005,824	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1315 | Period: From 10/01/2021 To 09/30/2022 | Worksheet D-1 | Date/Time Prepared: 2/22/2023 3:06 pm

Title XIX | 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)	6,870	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	5,513	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)	3,697	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	219	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)	1,043	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	23	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)	72	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	61	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)	344	15.00
16.00	Nursery days (title V or XIX only)	13	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	216.95	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	216.95	20.00
21.00	Total general inpatient routine service cost (see instructions)	14,965,234	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)	4,990	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)	15,620	25.00
26.00	Total swing-bed cost (see instructions)	2,804,393	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	12,160,841	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)	12,160,841	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	2,205.85	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	134,557	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)	134,557	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1315 | Period: From 10/01/2021 To 09/30/2022 | Worksheet D-1 | Date/Time Prepared: 2/22/2023 3:06 pm

Title XIX | 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)	259,194	344	753.47	13	9,795	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	421,580	130	3,242.92	4	12,972	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)	86,449	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	243,773	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)	23,356	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	7,770	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	31,126	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	212,647	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)	1,816	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,205.85	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	4,005,824	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1315 | Period: From 10/01/2021 To 09/30/2022 | Worksheet D-1 | Date/Time Prepared: 2/22/2023 3:06 pm

Title XIX | 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	2,087,901	14,965,234	0.139517	4,005,824	558,881	90.00
91.00	Nursing Program cost	0	14,965,234	0.000000	4,005,824	0	91.00
92.00	Allied health cost	0	14,965,234	0.000000	4,005,824	0	92.00
93.00	All other Medical Education	0	14,965,234	0.000000	4,005,824	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1315 | Period: From 10/01/2021 To 09/30/2022 | Worksheet D-3 | Date/Time Prepared: 2/22/2023 3:06 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		1,766,908		30.00
31.00	03100	INTENSIVE CARE UNIT		108,000		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.326640	370,481	121,014	50.00
51.00	05100	RECOVERY ROOM	0.402986	122,770	49,475	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.417045	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.144090	592,437	85,364	54.00
60.00	06000	LABORATORY	0.190162	811,712	154,357	60.00
65.00	06500	RESPIRATORY THERAPY	0.609969	362,791	221,291	65.00
65.01	06501	SLEEP LAB	0.149616	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.538732	243,182	131,010	66.00
69.00	06900	ELECTROCARDIOLOGY	0.104655	40,298	4,217	69.00
69.01	06901	CARDIAC REHABILITATION	0.461609	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.143677	294,469	42,308	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.896895	110,470	99,080	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.317013	719,664	228,143	73.00
76.00	03020	CHEMICAL DEPENDENCY	0.000000	0	0	76.00
76.01	03480	ONCOLOGY	0.126759	0	0	76.01
76.02	03030	DIABETIC EDUCATION	1.628070	6,400	10,420	76.02
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000		0	88.02
90.00	09000	CLINIC	0.614225	0	0	90.00
90.01	09001	CLINIC- ORTHO	17.393464	0	0	90.01
90.02	09002	CLINIC - PEDS ENT FP	2.119188	0	0	90.02
90.03	09003	INTRAVENOUS THERAPY	0.503451	0	0	90.03
90.04	09004	PSYCHIATRY	2.018656	0	0	90.04
90.05	09005	CARDIOLOGY	32.333011	0	0	90.05
91.00	09100	EMERGENCY	0.220598	135,004	29,782	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.393209	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		3,809,678	1,176,461	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)		3,809,678		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1315 | Component CCN: 15-Z315 | Period: From 10/01/2021 To 09/30/2022 | Worksheet D-3 | Date/Time Prepared: 2/22/2023 3:06 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.326640	5,925	1,935	50.00
51.00	05100	RECOVERY ROOM	0.402986	1,814	731	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.417045	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.144090	27,042	3,896	54.00
60.00	06000	LABORATORY	0.190162	101,994	19,395	60.00
65.00	06500	RESPIRATORY THERAPY	0.609969	18,050	11,010	65.00
65.01	06501	SLEEP LAB	0.149616	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.538732	425,815	229,400	66.00
69.00	06900	ELECTROCARDIOLOGY	0.104655	16,867	1,765	69.00
69.01	06901	CARDIAC REHABILITATION	0.461609	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.143677	28,993	4,166	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.896895	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.317013	67,609	21,433	73.00
76.00	03020	CHEMICAL DEPENDENCY	0.000000	0	0	76.00
76.01	03480	ONCOLOGY	0.126759	0	0	76.01
76.02	03030	DIABETIC EDUCATION	1.628070	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000		0	88.02
90.00	09000	CLINIC	0.614225	0	0	90.00
90.01	09001	CLINIC- ORTHO	17.393464	0	0	90.01
90.02	09002	CLINIC - PEDS ENT FP	2.119188	0	0	90.02
90.03	09003	INTRAVENOUS THERAPY	0.503451	0	0	90.03
90.04	09004	PSYCHIATRY	2.018656	0	0	90.04
90.05	09005	CARDIOLOGY	32.333011	0	0	90.05
91.00	09100	EMERGENCY	0.220598	90	20	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.393209	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		694,199	293,751	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)		694,199		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1315 | Period: From 10/01/2021 To 09/30/2022 | Worksheet D-3 | Date/Time Prepared: 2/22/2023 3:06 pm

Title XIX | 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		148,333		30.00
31.00	03100	INTENSIVE CARE UNIT		9,000		31.00
43.00	04300	NURSERY		10,000		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.326640	19,721	6,442	50.00
51.00	05100	RECOVERY ROOM	0.402986	10,648	4,291	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.417045	13,950	5,818	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.144090	52,158	7,515	54.00
60.00	06000	LABORATORY	0.190162	71,179	13,536	60.00
65.00	06500	RESPIRATORY THERAPY	0.609969	26,818	16,358	65.00
65.01	06501	SLEEP LAB	0.149616	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.538732	3,698	1,992	66.00
69.00	06900	ELECTROCARDIOLOGY	0.104655	3,960	414	69.00
69.01	06901	CARDIAC REHABILITATION	0.461609	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.143677	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.896895	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.317013	65,081	20,632	73.00
76.00	03020	CHEMICAL DEPENDENCY	0.000000	0	0	76.00
76.01	03480	ONCOLOGY	0.126759	0	0	76.01
76.02	03030	DIABETIC EDUCATION	1.628070	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.964586	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.853406	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.900834	0	0	88.02
90.00	09000	CLINIC	0.614225	0	0	90.00
90.01	09001	CLINIC- ORTHO	17.393464	0	0	90.01
90.02	09002	CLINIC - PEDS ENT FP	2.119188	0	0	90.02
90.03	09003	INTRAVENOUS THERAPY	0.503451	0	0	90.03
90.04	09004	PSYCHIATRY	2.018656	0	0	90.04
90.05	09005	CARDIOLOGY	32.333011	0	0	90.05
91.00	09100	EMERGENCY	0.220598	42,841	9,451	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.393209	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		310,054	86,449	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)		310,054		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-1315 | Period: From 10/01/2021 To 09/30/2022 | Worksheet E Part B Date/Time Prepared: 2/22/2023 3:06 pm

Title XVIII | Hospital | Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	12,135,979	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	OPPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	12,135,979	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	12,257,339	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	114,430	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	6,354,727	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)	5,788,182	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	5,788,182	30.00
31.00	Primary payer payments	6,163	31.00
32.00	Subtotal (line 30 minus line 31)	5,782,019	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)	460,862	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	299,560	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	366,909	36.00
37.00	Subtotal (see instructions)	6,081,579	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	6,081,579	40.00
40.01	Sequestration adjustment (see instructions)	45,612	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	6,044,955	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)	-8,988	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: 15-1315	Period: From 10/01/2021 To 09/30/2022	Worksheet E Part B Date/Time Prepared: 2/22/2023 3:06 pm
	Title XVIII	Hospital	Cost

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Provider CCN: 15-1315 | Period: From 10/01/2021 To 09/30/2022 | Worksheet E-1 Part I Date/Time Prepared: 2/22/2023 3:06 pm

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		3,168,116		6,044,955	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)		3,168,116		6,044,955	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		52,697		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		8,988	6.02
7.00	Total Medicare program liability (see instructions)		3,220,813		6,035,967	7.00

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-1315 | Component CCN: 15-Z315 | Period: From 10/01/2021 To 09/30/2022 | Worksheet E-1 Part I | Date/Time Prepared: 2/22/2023 3:06 pm

Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,405,725		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)		1,405,725		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		89,758		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,495,483		0	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-1315	Period: From 10/01/2021 To 09/30/2022	Worksheet E-1 Part II Date/Time Prepared: 2/22/2023 3:06 pm
	Title XVIII	Hospital	Cost

			1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14		1.00
2.00	Medicare days (Wkst. S-3, Pt. I, col. 6, sum of lines 1, and 8 through 12, and plus for cost reporting periods beginning on or after 10/01/2013, line 32)		2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2		3.00
4.00	Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of lines 1, and 8 through 12, and plus for cost reporting periods beginning on or after 10/01/2013, line 32)		4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200		5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20		6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168		7.00
8.00	Calculation of the HIT incentive payment (see instructions)		8.00
9.00	Sequestration adjustment amount (see instructions)		9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)		10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)		30.00
31.00	Other Adjustment (specify)		31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)		32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS | Provider CCN: 15-1315 | Component CCN: 15-Z315 | Period: From 10/01/2021 To 09/30/2022 | Worksheet E-2 | Date/Time Prepared: 2/22/2023 3:06 pm

Title XVIII | Swing Beds - SNF | Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	1,229,805	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swing-bed pass-through, see instructions)	296,689	0	3.00
3.01	Nursing and allied health payment-PARHM (see instructions)			3.01
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	552	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	1,526,494	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	1,526,494	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	1,526,494	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	19,710	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (see instructions)	1,506,784	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			16.50
16.55	Rural community hospital demonstration project (§410A Demonstration) payment adjustment (see instructions)	0		16.55
16.99	Demonstration payment adjustment amount before sequestration	0	0	16.99
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	1,506,784	0	19.00
19.01	Sequestration adjustment (see instructions)	11,301	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0	0	19.02
19.03	Sequestration adjustment-PARHM pass-throughs			19.03
19.25	Sequestration for non-claims based amounts (see instructions)	0	0	19.25
20.00	Interim payments	1,405,725	0	20.00
20.01	Interim payments-PARHM			20.01
21.00	Tentative settlement (for contractor use only)	0	0	21.00
21.01	Tentative settlement-PARHM (for contractor use only)			21.01
22.00	Balance due provider/program (line 19 minus lines 19.01, 19.02, 19.25, 20, and 21)	89,758	0	22.00
22.01	Balance due provider/program-PARHM (see instructions)			22.01
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	23.00
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
	Cost Reimbursement			
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))			201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))			202.00
203.00	Total (sum of lines 201 and 202)			203.00
204.00	Medicare swing-bed SNF discharges (see instructions)			204.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
205.00	Medicare swing-bed SNF target amount			205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)			206.00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)			208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
	Comparision of PPS versus Cost Reimbursement			
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)			215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1315	Period: From 10/01/2021 To 09/30/2022	Worksheet E-3 Part V Date/Time Prepared: 2/22/2023 3:06 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	3,514,497	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)	0	2.00
3.00	Organ acquisition	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	3,514,497	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	3,549,642	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	3,549,642	19.00
20.00	Deductibles (exclude professional component)	322,512	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	3,227,130	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	3,227,130	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	27,726	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	18,022	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	19,042	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	3,245,152	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29.98	Recovery of accelerated depreciation.	0	29.98
29.99	Demonstration payment adjustment amount before sequestration	0	29.99
30.00	Subtotal (see instructions)	3,245,152	30.00
30.01	Sequestration adjustment (see instructions)	24,339	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
30.03	Sequestration adjustment-PARHM		30.03
31.00	Interim payments	3,168,116	31.00
31.01	Interim payments-PARHM		31.01
32.00	Tentative settlement (for contractor use only)	0	32.00
32.01	Tentative settlement-PARHM (for contractor use only)		32.01
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)	52,697	33.00
33.01	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01)		33.01
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-1315 | Period: From 10/01/2021 To 09/30/2022 | Worksheet E-3 Part VII Date/Time Prepared: 2/22/2023 3:06 pm

Title XIX | Hospital | PPS

		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	36,553		8.00
9.00	Ancillary service charges	310,054	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)	346,607	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)	346,607	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	346,607	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	126,306	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)	126,306	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)	126,306	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)	126,306	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	261	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)	126,045	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	126,045	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)	126,045	0	40.00
41.00	Interim payments	126,045	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 15-1315 | Period: From 10/01/2021 To 09/30/2022 | Worksheet G | Date/Time Prepared: 2/22/2023 3:06 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	21,564,054	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	11,581,034	0	0	0	4.00
5.00	Other receivable	1,363,610	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	1,529,058	0	0	0	7.00
8.00	Prepaid expenses	2,613,081	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	38,650,837	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	2,019,703	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	61,152,127	0	0	0	15.00
16.00	Accumulated depreciation	-31,765,450	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	19,762,922	0	0	0	23.00
24.00	Accumulated depreciation	-15,945,945	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	212,917	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	35,436,274	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	27,994,311	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	4,226,503	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	32,220,814	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	106,307,925	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	3,141,788	0	0	0	37.00
38.00	Salaries, wages, and fees payable	5,644,116	0	0	0	38.00
39.00	Payroll taxes payable	747,002	0	0	0	39.00
40.00	Notes and loans payable (short term)	960,667	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	2,131,754	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	12,625,327	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	39,832,903	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	39,832,903	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	52,458,230	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	53,849,695				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)	53,849,695	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	106,307,925	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-1315 | Period: From 10/01/2021 To 09/30/2022 | Worksheet G-1 | Date/Time Prepared: 2/22/2023 3:06 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		49,027,962		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		4,821,721				2.00
3.00	Total (sum of line 1 and line 2)		53,849,683		0		3.00
4.00	ROUNDING	12		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)		12		0		10.00
11.00	Subtotal (line 3 plus line 10)		53,849,695		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		53,849,695		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	ROUNDING		0		4.00
5.00			0		5.00
6.00			0		6.00
7.00			0		7.00
8.00			0		8.00
9.00			0		9.00
10.00	Total additions (sum of line 4-9)	0		0	10.00
11.00	Subtotal (line 3 plus line 10)	0		0	11.00
12.00	Deductions (debit adjustments) (specify)		0		12.00
13.00			0		13.00
14.00			0		14.00
15.00			0		15.00
16.00			0		16.00
17.00			0		17.00
18.00	Total deductions (sum of lines 12-17)	0		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0	19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 15-1315 | Period: From 10/01/2021 To 09/30/2022 | Worksheet G-2 Parts I & II | Date/Time Prepared: 2/22/2023 3:06 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	12,260,860		12,260,860	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	12,260,860		12,260,860	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	393,000		393,000	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)	393,000		393,000	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	12,653,860		12,653,860	17.00
18.00	Ancillary services	19,906,300	170,747,692	190,653,992	18.00
19.00	Outpatient services	0	10,198,177	10,198,177	19.00
20.00	RURAL HEALTH CLINIC	10,672	2,169,275	2,179,947	20.00
20.01	RURAL HEALTH CLINIC II	0	3,729,278	3,729,278	20.01
20.02	RURAL HEALTH CLINIC III	740,113	1,255,961	1,996,074	20.02
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		0	0	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE	0	0	0	26.00
27.00	NON REIMBURSABLE	0	4,103,728	4,103,728	27.00
27.01	PROFESSIONAL FEES	191,890	4,584,878	4,776,768	27.01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	33,502,835	196,788,989	230,291,824	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		88,005,938		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)		88,005,938		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-1315 | Period: From 10/01/2021 To 09/30/2022 | Worksheet G-3 | Date/Time Prepared: 2/22/2023 3:06 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	230,291,824	1.00
2.00	Less contractual allowances and discounts on patients' accounts	135,237,706	2.00
3.00	Net patient revenues (line 1 minus line 2)	95,054,118	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	88,005,938	4.00
5.00	Net income from service to patients (line 3 minus line 4)	7,048,180	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	-28,333	6.00
7.00	Income from investments	78,076	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	268,979	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER OPERATING INCOME	521,689	24.00
24.01	340B CONTRACT REVENUE	299,973	24.01
24.02	PHYISICAN INCENTIVE PAYMENTS	104,400	24.02
24.50	COVID-19 PHE Funding	2,065,351	24.50
25.00	Total other income (sum of lines 6-24)	3,310,135	25.00
26.00	Total (line 5 plus line 25)	10,358,315	26.00
27.00	LOSS ON DISPOSAL OF PROPERTY	39,403	27.00
27.01	UNREALIZED LOSS ON INVESTMENT	5,497,191	27.01
28.00	Total other expenses (sum of line 27 and subscripts)	5,536,594	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	4,821,721	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1315 | Component CCN: 15-8530 | Period: From 10/01/2021 To 09/30/2022 | Worksheet M-1 | Date/Time Prepared: 2/22/2023 3:06 pm

RHC I | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	406,007	32,084	438,091	102,494	540,585	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	227,663	0	227,663	51,247	278,910	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	307,188	0	307,188	0	307,188	5.00
6.00	Clinical Psychologist	0	0	0	17,642	17,642	6.00
7.00	Clinical Social Worker	17,544	0	17,544	0	17,544	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	41,123	0	41,123	0	41,123	9.00
10.00	Subtotal (sum of lines 1 through 9)	999,525	32,084	1,031,609	171,383	1,202,992	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	32,148	32,148	0	32,148	15.00
16.00	Transportation (Health Care Staff)	0	6,045	6,045	0	6,045	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	38,193	38,193	0	38,193	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	999,525	70,277	1,069,802	171,383	1,241,185	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	9,816	9,816	0	9,816	29.00
30.00	Administrative Costs	85,776	31,764	117,540	0	117,540	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	85,776	41,580	127,356	0	127,356	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,085,301	111,857	1,197,158	171,383	1,368,541	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1315 | Component CCN: 15-8530 | Period: From 10/01/2021 To 09/30/2022 | Worksheet M-1 | Date/Time Prepared: 2/22/2023 3:06 pm

RHC I | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	540,585		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	278,910		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	307,188		5.00
6.00	Clinical Psychologist	0	17,642		6.00
7.00	Clinical Social Worker	0	17,544		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	41,123		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	1,202,992		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	32,148		15.00
16.00	Transportation (Health Care Staff)	0	6,045		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	38,193		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	1,241,185		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	0		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	9,816		29.00
30.00	Administrative Costs	0	117,540		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	127,356		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	1,368,541		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1315 | Component CCN: 15-8545 | Period: From 10/01/2021 To 09/30/2022 | Worksheet M-1 | Date/Time Prepared: 2/22/2023 3:06 pm

RHC II | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	513,470	0	513,470	108,839	622,309	1.00
2.00	Physician Assistant	139,563	0	139,563	54,419	193,982	2.00
3.00	Nurse Practitioner	274,913	0	274,913	54,419	329,332	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	229,823	0	229,823	0	229,823	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	179,784	0	179,784	0	179,784	9.00
10.00	Subtotal (sum of lines 1 through 9)	1,337,553	0	1,337,553	217,677	1,555,230	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	178,466	178,466	0	178,466	15.00
16.00	Transportation (Health Care Staff)	0	95	95	0	95	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	178,561	178,561	0	178,561	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,337,553	178,561	1,516,114	217,677	1,733,791	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	17,580	17,580	0	17,580	29.00
30.00	Administrative Costs	240,040	71,142	311,182	0	311,182	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	240,040	88,722	328,762	0	328,762	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,577,593	267,283	1,844,876	217,677	2,062,553	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1315 | Component CCN: 15-8545 | Period: From 10/01/2021 To 09/30/2022 | Worksheet M-1 | Date/Time Prepared: 2/22/2023 3:06 pm

RHC II | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	622,309		1.00
2.00	Physician Assistant	0	193,982		2.00
3.00	Nurse Practitioner	0	329,332		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	229,823		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	179,784		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	1,555,230		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	178,466		15.00
16.00	Transportation (Health Care Staff)	0	95		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	178,561		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	1,733,791		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	0		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	17,580		29.00
30.00	Administrative Costs	0	311,182		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	328,762		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	2,062,553		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1315 | Component CCN: 15-8546 | Period: From 10/01/2021 To 09/30/2022 | Worksheet M-1 | Date/Time Prepared: 2/22/2023 3:06 pm

RHC III | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	687,045	200,567	887,612	98,342	985,954	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	161,365	0	161,365	49,171	210,536	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	89,988	0	89,988	0	89,988	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	106,951	0	106,951	0	106,951	9.00
10.00	Subtotal (sum of lines 1 through 9)	1,045,349	200,567	1,245,916	147,513	1,393,429	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	10,037	10,037	0	10,037	15.00
16.00	Transportation (Health Care Staff)	0	4,766	4,766	0	4,766	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	14,803	14,803	0	14,803	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,045,349	215,370	1,260,719	147,513	1,408,232	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	60,160	60,160	0	60,160	29.00
30.00	Administrative Costs	74,702	30,240	104,942	0	104,942	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	74,702	90,400	165,102	0	165,102	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,120,051	305,770	1,425,821	147,513	1,573,334	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1315 | Component CCN: 15-8546 | Period: From 10/01/2021 To 09/30/2022 | Worksheet M-1 | Date/Time Prepared: 2/22/2023 3:06 pm

RHC III | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	-195,363	790,591		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	-97,681	112,855		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	89,988		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	106,951		9.00
10.00	Subtotal (sum of lines 1 through 9)	-293,044	1,100,385		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	10,037		15.00
16.00	Transportation (Health Care Staff)	0	4,766		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	14,803		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-293,044	1,115,188		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	0		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	60,160		29.00
30.00	Administrative Costs	0	104,942		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	165,102		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-293,044	1,280,290		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-1315 Component CCN: 15-8530

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

Worksheet M-2

Date/Time Prepared: 2/22/2023 3:06 pm

RHC I

Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.63	3,462	4,200	2,646		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	1.45	5,657	2,100	3,045		3.00
4.00	Subtotal (sum of lines 1 through 3)	2.08	9,119		5,691	9,119	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.29	248			248	6.00
7.00	Clinical Social Worker	0.24	191			191	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)	2.61	9,558			9,558	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					1,241,185	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					1,241,185	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					127,356	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					734,205	15.00
16.00	Total overhead (sum of lines 14 and 15)					861,561	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					861,561	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					861,561	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					2,102,746	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-1315 | Component CCN: 15-8545 | Period: From 10/01/2021 To 09/30/2022 | Worksheet M-2 | Date/Time Prepared: 2/22/2023 3:06 pm

RHC II | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	1.33	4,742	4,200	5,586		1.00
2.00	Physician Assistant	0.56	3,869	2,100	1,176		2.00
3.00	Nurse Practitioner	1.49	10,135	2,100	3,129		3.00
4.00	Subtotal (sum of lines 1 through 3)	3.38	18,746		9,891	18,746	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)	3.38	18,746			18,746	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					1,733,791	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					1,733,791	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					328,762	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					1,120,034	15.00
16.00	Total overhead (sum of lines 14 and 15)					1,448,796	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					1,448,796	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					1,448,796	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					3,182,587	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-1315 Component CCN: 15-8546

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

Worksheet M-2

Date/Time Prepared: 2/22/2023 3:06 pm

RHC III

Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.40	2,260	4,200	1,680		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	0.88	3,357	2,100	1,848		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.28	5,617		3,528	5,617	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)	1.28	5,617			5,617	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					1,115,188	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					1,115,188	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					165,102	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					517,842	15.00
16.00	Total overhead (sum of lines 14 and 15)					682,944	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					682,944	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					682,944	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					1,798,132	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 15-1315 Component CCN: 15-8530	Period: From 10/01/2021 To 09/30/2022	Worksheet M-3 Date/Time Prepared: 2/22/2023 3:06 pm
	Title XVIII	RHC I	Cost

			1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)		2,102,746	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)		62,216	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)		2,040,530	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		9,558	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)		0	5.00
6.00	Total adjusted visits (line 4 plus line 5)		9,558	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		213.49	7.00

		Calculation of Limit (1)		
		Rate Period 1 (10/01/2021 through 12/31/2021)	Rate Period 2 (01/01/2022 through 09/30/2022)	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	269.63	275.29	8.00
9.00	Rate for Program covered visits (see instructions)	213.49	213.49	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	292	868	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	62,339	185,309	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	247,648	16.00
16.01	Total program charges (see instructions)(from contractor's records)		228,651	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		6,764	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		7,326	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.)		167,799	16.04
16.05	Total program cost (see instructions)	0	175,125	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		30,573	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		38,262	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		175,125	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		50,512	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		225,637	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)		225,637	26.00
26.01	Sequestration adjustment (see instructions)		1,692	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		230,429	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)		-6,484	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: 15-1315 Component CCN: 15-8545	Period: From 10/01/2021 To 09/30/2022	Worksheet M-3 Date/Time Prepared: 2/22/2023 3:06 pm
	Title XVIII	RHC II	Cost

			1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)		3,182,587	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)		0	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)		3,182,587	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		18,746	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)		18,746	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		169.77	7.00

		Calculation of Limit (1)		
		Rate Period 1 (10/01/2021 through 12/31/2021)	Rate Period 2 (01/01/2022 through 09/30/2022)	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	223.90	228.60	8.00
9.00	Rate for Program covered visits (see instructions)	169.77	169.77	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	303	898	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	51,440	152,453	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	203,893	16.00
16.01	Total program charges (see instructions)(from contractor's records)		223,079	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		14,757	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		13,488	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.)		130,282	16.04
16.05	Total program cost (see instructions)	0	143,770	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		27,552	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		36,154	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		143,770	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		0	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		143,770	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)		143,770	26.00
26.01	Sequestration adjustment (see instructions)		1,078	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		159,332	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)		-16,640	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: 15-1315 Component CCN: 15-8546	Period: From 10/01/2021 To 09/30/2022	Worksheet M-3 Date/Time Prepared: 2/22/2023 3:06 pm
	Title XVIII	RHC III	Cost

				1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			1,798,132	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			6,788	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			1,791,344	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			5,617	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)			5,617	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			318.91	7.00
		Calculation of Limit (1)			
		Rate Period 1 (10/01/2021 through 12/31/2021)	Rate Period 2 (01/01/2022 through 09/30/2022)		
		1.00	2.00		
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	451.79	461.27		8.00
9.00	Rate for Program covered visits (see instructions)	318.91	318.91		9.00
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	32	93		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	10,205	29,659		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	39,864		16.00
16.01	Total program charges (see instructions)(from contractor's records)		30,955		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		2,834		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		3,650		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.)		27,944		16.04
16.05	Total program cost (see instructions)	0	31,594		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		1,284		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		5,367		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		31,594		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		146		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		31,740		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)		31,740		26.00
26.01	Sequestration adjustment (see instructions)		238		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		31,143		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)		359		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: 15-1315 | Component CCN: 15-8530 | Period: From 10/01/2021 To 09/30/2022 | Worksheet M-4 | Date/Time Prepared: 2/22/2023 3:06 pm

Title XVIII | RHC I | Cost

		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	1,202,992	1,202,992	1,202,992	1,202,992	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000306	0.001906	0.000699	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	368	2,293	841	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	13,907	19,315	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	14,275	21,608	841	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	1,241,185	1,241,185	1,241,185	1,241,185	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	861,561	861,561	861,561	861,561	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.011501	0.017409	0.000678	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	9,909	14,999	584	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	24,184	36,607	1,425	0	10.00
11.00	Total number of injections/infusions (from your records)	77	480	176	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	314.08	76.26	8.10	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	72	350	121	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			28	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)	22,614	26,691	1,207	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)		62,216			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)		50,512			16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 15-1315 | Component CCN: 15-8546 | Period: From 10/01/2021 To 09/30/2022 | Worksheet M-4 | Date/Time Prepared: 2/22/2023 3:06 pm

Title XVIII | RHC III | Cost

		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	1,100,385	1,100,385	1,100,385	1,100,385	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000000	0.000425	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	0	468	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	0	3,742	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	0	4,210	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	1,115,188	1,115,188	1,115,188	1,115,188	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	682,944	682,944	682,944	682,944	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.000000	0.003775	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	0	2,578	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	0	6,788	0	0	10.00
11.00	Total number of injections/infusions (from your records)	0	93	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	0.00	72.99	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	0	2	0	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	0	146	0	0	14.00
15.00	Total cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. M-3, line 2)		6,788			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)		146			16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 15-1315 Component CCN: 15-8530	Period: From 10/01/2021 To 09/30/2022	Worksheet M-5 Date/Time Prepared: 2/22/2023 3:06 pm
		RHC I	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		230,429	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)		230,429	4.00
	TO BE COMPLETED BY CONTRACTOR			
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
	Program to Provider			
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
	Provider to Program			
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		0	6.01
6.02	SETTLEMENT TO PROGRAM		6,484	6.02
7.00	Total Medicare program liability (see instructions)		223,945	7.00

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

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 15-1315 Component CCN: 15-8545	Period: From 10/01/2021 To 09/30/2022	Worksheet M-5 Date/Time Prepared: 2/22/2023 3:06 pm
		RHC II	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		159,332	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)		159,332	4.00
	TO BE COMPLETED BY CONTRACTOR			
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
	Program to Provider			
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
	Provider to Program			
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		0	6.01
6.02	SETTLEMENT TO PROGRAM		16,640	6.02
7.00	Total Medicare program liability (see instructions)		142,692	7.00

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

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 15-1315 Component CCN: 15-8546	Period: From 10/01/2021 To 09/30/2022	Worksheet M-5 Date/Time Prepared: 2/22/2023 3:06 pm
		RHC III	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		31,143	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)		31,143	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		359	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		31,502	7.00

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