This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g).

FORM APPROVED
OMB NO. 0938-0050
EXPIRES 09-30-2025

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 15-1324	Period: From 01/01/2022 To 12/31/2022	Worksheet S Parts I-III Date/Time Prepared: 5/29/2023 3:36 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 5/29/2023 Time: 3:36 pm
2. [ ] Manually prepared cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no.

Contractor use only

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

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

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by FRANCISCAN HEALTH RENSSELAER (15-1324) for the cost reporting period beginning 01/01/2022 and ending 12/31/2022 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR		CHECKBOX	ELECTRONIC SIGNATURE STATEMENT	
	1		2		
1				I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name				2
3	Signatory Title				3
4	Date				4

		Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	HOSPITAL	0	-170,539	-1,234,935	0	-12,171	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	68,635	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		1,315		0	10.00
10.01	RURAL HEALTH CLINIC II	0		14,457		0	10.01
200.00	TOTAL	0	-101,904	-1,219,163	0	-12,171	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1324 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-2 Part I | Date/Time Prepared: 5/29/2023 3:36 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1104 EAST GRACE STREET	PO Box:			1.00
2.00	City: RENSSELAER	State: IN	Zip Code: 47978	County: JASPER	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	FRANCISCAN HEALTH RENSSELAER	151324	23844	1	02/03/2005	N	O	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	FRANCISCAN HEALTH RENSSELAER	15Z324	99915		12/31/2005	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC	WHEATFIELD CLINIC	153990	99915		10/07/1999	N	O	N	15.00
15.01	Hospital-Based Health Clinic - RHC II	BROOK	158502	99915		01/01/2005	N	O	N	15.01
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2022	12/31/2022	20.00
21.00	Type of Control (see instructions)	1		21.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1324 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-2 Part I | Date/Time Prepared: 5/29/2023 3:36 pm

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1324	Period: From 01/01/2022 To 12/31/2022	Worksheet S-2 Part I Date/Time Prepared: 5/29/2023 3:36 pm

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

		NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
		1.00	2.00	3.00	
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.	N			60.00

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	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: 15-1324 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-2 Part I | Date/Time Prepared: 5/29/2023 3:36 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: 15-1324 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-2 Part I Date/Time Prepared: 5/29/2023 3:36 pm

		1.00	
	Direct GME in Accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022)		
68.00	For a cost reporting period beginning prior to October 1, 2022, did you obtain permission from your MAC to apply the new DGME formula in accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022)?	N	68.00

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

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

		Approved for Permanent Adjustment (Y/N)	Number of Approved Permanent Adjustments	
		1.00	2.00	
88.00	Column 1: Is this hospital approved for a permanent adjustment to the TEFRA target amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete col. 2 and line 89. (see instructions) Column 2: Enter the number of approved permanent adjustments.		0	88.00

		Wkst. A Line No.	Effective Date	Approved Permanent Adjustment Amount Per Discharge	
		1.00	2.00	3.00	
89.00	Column 1: If line 88, column 1 is Y, enter the Worksheet A line number on which the per discharge permanent adjustment approval was based. Column 2: Enter the effective date (i.e., the cost reporting period beginning date) for the permanent adjustment to the TEFRA target amount per discharge. Column 3: Enter the amount of the approved permanent adjustment to the TEFRA target amount per discharge.	0.00		0	89.00

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1324 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-2 Part I Date/Time Prepared: 5/29/2023 3:36 pm

		V	XIX	
		1.00	2.00	
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	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
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N	109.00

		1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration)for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.	N	110.00

		1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N		111.00

		1.00	2.00	3.00	
112.00	Did this hospital participate in the Pennsylvania Rural Health Model (PARHM) demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N			112.00
113.00	Did this hospital participate in the Community Health Access and Rural Transformation (CHART) model for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no.				113.00
	Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1324 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-2 Part I | Date/Time Prepared: 5/29/2023 3:36 pm

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	236,962	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
123.00	Did the facility and/or its subproviders (if applicable) purchase professional services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, and/or management/consulting services, from an unrelated organization? In column 1, enter "Y" for yes or "N" for no. If column 1 is "Y", were the majority of the expenses, i.e., greater than 50% of total professional services expenses, for services purchased from unrelated organizations located in a CBSA outside of the main hospital CBSA? In column 2, enter "Y" for yes or "N" for no.			123.00
	Certified Transplant Center Information			
125.00	Does this facility operate a Medicare-certified transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare-certified kidney transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare-certified heart transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare-certified liver transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare-certified lung transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare-certified pancreas transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare-certified intestinal transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare-certified islet transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is a hospital-based organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	158014	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: FRANCISCAN ALLIANCE INC	Contractor's Name: WPS	Contractor's Number: 08101	141.00
142.00	Street: 1515 W. DRAGOON TRAIL	PO Box: 1290		142.00
143.00	City: MISHAWAKA	State: IN	Zip Code: 46546-1290	143.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1324 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-2 Part I | Date/Time Prepared: 5/29/2023 3:36 pm

						1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.					N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.					N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.					N	149.00
		Part A	Part B	Title V	Title XIX		
		1.00	2.00	3.00	4.00		
	Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)						
155.00	Hospital	N	N	N	N		155.00
156.00	Subprovider - IPF	N	N	N	N		156.00
157.00	Subprovider - IRF	N	N	N	N		157.00
158.00	SUBPROVIDER						158.00
159.00	SNF	N	N	N	N		159.00
160.00	HOME HEALTH AGENCY	N	N	N	N		160.00
161.00	CMHC		N	N	N		161.00
						1.00	
	Multicampus						
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.					N	165.00

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

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

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170.00
		1.00	2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N	0	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1324 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-2 Part II | Date/Time Prepared: 5/29/2023 3:36 pm

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

		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	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		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	N		N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	04/06/2023	Y	04/06/2023	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: 15-1324 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-2 Part II Date/Time Prepared: 5/29/2023 3:36 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.				N	33.00
	Provider-Based Physicians					
34.00	Were services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				Y	35.00
				Y/N	Date	
				1.00	2.00	
	Home Office Costs					
36.00	Were home office costs claimed on the cost report?			Y		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.			Y		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			N		40.00
		1.00		2.00		
	Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	HONG		YANG		41.00
42.00	Enter the employer/company name of the cost report preparer.	FRANCISCAN ALLIANCE				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	219-407-6568		HONG.YANG@FRANCISCANALLIANCE.ORG		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-1324	Period: From 01/01/2022 To 12/31/2022	Worksheet S-2 Part II Date/Time Prepared: 5/29/2023 3:36 pm

		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DIRECTOR REIMBURSEMENT		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: 15-1324 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-3 Part I | Date/Time Prepared: 5/29/2023 3:36 pm

	Component	Worksheet A Line No.	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	25	9,125	35,644.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		25	9,125	35,644.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	0	0	0.00	0	8.00
9.00	CORONARY CARE UNIT	32.00	0	0	0.00	0	9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		25	9,125	35,644.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)	115.00					23.00
24.00	HOSPICE	116.00	0	0			24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	88.00				0	26.00
26.01	RURAL HEALTH CLINIC II	88.01				0	26.01
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		25				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care	30.00	0	0		0	34.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1324 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-3 Part I | Date/Time Prepared: 5/29/2023 3:36 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	632	12	1,486			1.00
2.00	HMO and other (see instructions)	284	74				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	366	0	366			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	305			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	998	12	2,157			7.00
8.00	INTENSIVE CARE UNIT	0	0	0			8.00
9.00	CORONARY CARE UNIT	0	0	0			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)	998	12	2,157	0.00	129.77	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.)				0.00	0.00	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	238	348	924	0.00	3.29	26.00
26.01	RURAL HEALTH CLINIC II	498	728	1,710	0.00	4.05	26.01
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	137.11	27.00
28.00	Observation Bed Days		132	674			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	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care	0	0	0			34.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1324 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-3 Part I | Date/Time Prepared: 5/29/2023 3:36 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	237	4	456	1.00
2.00	HMO and other (see instructions)			78	20		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	237	4	456	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.)	0.00					23.00
24.00	HOSPICE	0.00					24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0.00					26.00
26.01	RURAL HEALTH CLINIC II	0.00					26.01
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care						34.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-1324 | Component CCN: 15-3990 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-8 | Date/Time Prepared: 5/29/2023 3:36 pm

RHC I | Cost

					1.00	
	Clinic Address and Identification					
1.00	Street			429 S BIERMA ST		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	WHEATFIELD		IN	47978	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00
		Sunday		Monday		Tuesday
		from	to	from	to	from
		1.00	2.00	3.00	4.00	5.00
	Facility hours of operations (1)					
11.00	CLINIC			07:00	16:30	07:00
					1.00	2.00
12.00	Have you received an approval for an exception to the productivity standard?				Y	12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.				N	0 13.00
				Provider name		CCN
				1.00		2.00
14.00	RHC/FQHC name, CCN					14.00
		Y/N	V	XVIII	XIX	Total Visits
		1.00	2.00	3.00	4.00	5.00
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)					15.00
			County			
			4.00			
2.00	City, State, ZIP Code, County					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	07:00	16:30		11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 15-1324
Component CCN: 15-3990

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

Worksheet S-8
Date/Time Prepared:
5/29/2023 3:36 pm

RHC I | Cost

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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-1324 | Component CCN: 15-8502 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-8 | Date/Time Prepared: 5/29/2023 3:36 pm

RHC II | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			1104 E GRACE ST		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	RENSSELAER		IN	47978	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	CLINIC			07:00	16:30	07:00	11.00

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

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

			County				
			4.00				
2.00	City, State, ZIP Code, County						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	07:00	16:30	07:00	16:30	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 15-1324
Component CCN: 15-8502

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

Worksheet S-8
Date/Time Prepared:
5/29/2023 3:36 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						11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-1324 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-10 | Date/Time Prepared: 5/29/2023 3:36 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)	0.337466	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	3,513,185	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	N	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	N	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	19,051,925	6.00
7.00	Medicaid cost (line 1 times line 6)	6,429,377	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)	2,916,192	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)	2,916,192	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	2,871,731	0	2,871,731	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	969,112	0	969,112	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)	969,112	0	969,112	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)	2,282,206	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	348,010	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	535,400	27.01
28.00	Non-Medicare bad debt expense (see instructions)	1,746,806	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	776,878	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,745,990	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	4,662,182	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1324 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A | Date/Time Prepared: 5/29/2023 3:36 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		2,690,406	2,690,406	39,431	2,729,837	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	0	0	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-100,710	3,426,501	3,325,791	0	3,325,791	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,434,186	6,501,907	10,936,093	-39,431	10,896,662	5.00
7.00	00700	OPERATION OF PLANT	409,933	1,311,154	1,721,087	0	1,721,087	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	17,014	1,698	18,712	0	18,712	8.00
9.00	00900	HOUSEKEEPING	426,407	109,140	535,547	-33,768	501,779	9.00
10.00	01000	DIETARY	264,673	148,764	413,437	-265,893	147,544	10.00
11.00	01100	CAFETERIA	0	0	0	265,893	265,893	11.00
13.00	01300	NURSING ADMINISTRATION	143,579	111,233	254,812	0	254,812	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14,450	60,085	74,535	-973	73,562	14.00
15.00	01500	PHARMACY	322,664	2,819,304	3,141,968	-2,761,726	380,242	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	1,965,250	328,690	2,293,940	-169	2,293,771	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
32.00	03200	CORONARY CARE UNIT	0	0	0	0	0	32.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	618,108	334,030	952,138	30,601	982,739	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,084,206	399,686	1,483,892	-36,139	1,447,753	54.00
60.00	06000	LABORATORY	0	2,514,228	2,514,228	-297	2,513,931	60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	0	7,471	7,471	0	7,471	63.00
65.00	06500	RESPIRATORY THERAPY	662,893	58,060	720,953	0	720,953	65.00
66.00	06600	PHYSICAL THERAPY	485,123	31,325	516,448	-279	516,169	66.00
66.01	06601	PHYSICAL THERAPY- WHEATFIELD	277,868	8,577	286,445	-1,260	285,185	66.01
67.00	06700	OCCUPATIONAL THERAPY	136,165	3,884	140,049	0	140,049	67.00
67.01	06701	OCCUPATIONAL THERAPY- WHEATFIELD	78,931	4,126	83,057	0	83,057	67.01
68.00	06800	SPEECH PATHOLOGY	98,498	1,953	100,451	0	100,451	68.00
68.01	06801	SPEECH PATHOLOGY- WHEATFIELD	142,869	5,084	147,953	0	147,953	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	694,760	694,760	0	694,760	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	143,687	143,687	0	143,687	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	2,832,634	2,832,634	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	236,990	40,381	277,371	-11,228	266,143	88.00
88.01	08801	RURAL HEALTH CLINIC II	276,810	30,928	307,738	-15,609	292,129	88.01
90.00	09000	CLINIC	881,654	475,449	1,357,103	-58	1,357,045	90.00
90.01	09001	WOUND CARE	14,204	3,513	17,717	-445	17,272	90.01
91.00	09100	EMERGENCY	1,248,419	1,318,513	2,566,932	-1,284	2,565,648	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		0	0	0	0	113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	14,140,184	23,584,537	37,724,721	0	37,724,721	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	1,673	1,673	0	1,673	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	72	72	0	72	192.00
194.00	07950	ALTERNACARE	0	175	175	0	175	194.00
194.01	07951	SPORTS MEDICINE	0	85	85	0	85	194.01
194.02	07952	UNUSED SPACE	0	0	0	0	0	194.02
194.03	07953	LAFAYETTE HHA BRANCH	0	0	0	0	0	194.03
200.00		TOTAL (SUM OF LINES 118 through 199)	14,140,184	23,586,542	37,726,726	0	37,726,726	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1324 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A | Date/Time Prepared: 5/29/2023 3:36 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	297,202	3,027,039		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	0		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-812,458	2,513,333		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-1,568,981	9,327,681		5.00
7.00	00700	OPERATION OF PLANT	-7,780	1,713,307		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	18,712		8.00
9.00	00900	HOUSEKEEPING	0	501,779		9.00
10.00	01000	DIETARY	0	147,544		10.00
11.00	01100	CAFETERIA	-75,438	190,455		11.00
13.00	01300	NURSING ADMINISTRATION	223,303	478,115		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-114,147	-40,585		14.00
15.00	01500	PHARMACY	49,714	429,956		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	417,617	417,617		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-531,088	1,762,683		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0		31.00
32.00	03200	CORONARY CARE UNIT	0	0		32.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-220,055	762,684		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-28,838	1,418,915		54.00
60.00	06000	LABORATORY	0	2,513,931		60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	0	7,471		63.00
65.00	06500	RESPIRATORY THERAPY	-9,769	711,184		65.00
66.00	06600	PHYSICAL THERAPY	-1,808	514,361		66.00
66.01	06601	PHYSICAL THERAPY- WHEATFIELD	0	285,185		66.01
67.00	06700	OCCUPATIONAL THERAPY	-510	139,539		67.00
67.01	06701	OCCUPATIONAL THERAPY- WHEATFIELD	0	83,057		67.01
68.00	06800	SPEECH PATHOLOGY	0	100,451		68.00
68.01	06801	SPEECH PATHOLOGY- WHEATFIELD	0	147,953		68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	694,760		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	143,687		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,832,634		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	-14,719	251,424		88.00
88.01	08801	RURAL HEALTH CLINIC II	-36,046	256,083		88.01
90.00	09000	CLINIC	-403,823	953,222		90.00
90.01	09001	WOUND CARE	0	17,272		90.01
91.00	09100	EMERGENCY	-33	2,565,615		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	0		95.00
101.00	10100	HOME HEALTH AGENCY	0	0		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0		115.00
116.00	11600	HOSPICE	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-2,837,657	34,887,064		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	1,673		190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	72		192.00
194.00	07950	ALTERNACARE	0	175		194.00
194.01	07951	SPORTS MEDICINE	0	85		194.01
194.02	07952	UNUSED SPACE	0	0		194.02
194.03	07953	LAFAYETTE HHA BRANCH	0	0		194.03
200.00		TOTAL (SUM OF LINES 118 through 199)	-2,837,657	34,889,069		200.00

RECLASSIFICATIONS | Provider CCN: 15-1324 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-6 | Date/Time Prepared: 5/29/2023 3:36 pm

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - CAFETERIA				
1.00	CAFETERIA	11.00	170,219	95,674	1.00
	0		170,219	95,674	
	B - PROPERTY INSURANCE				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	39,431	1.00
	0		0	39,431	
	C - HOUSEKEEPING				
1.00	OPERATING ROOM	50.00	33,768	0	1.00
	0		33,768	0	
	D - DRUGS				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	2,832,634	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
	0		0	2,832,634	
500.00	Grand Total: Increases		203,987	2,967,739	500.00

RECLASSIFICATIONS | Provider CCN: 15-1324 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-6 | Date/Time Prepared: 5/29/2023 3:36 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - CAFETERIA						
1.00	DIETARY	10.00	170,219	95,674	0		1.00
	0		170,219	95,674			
	B - PROPERTY INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	39,431	12		1.00
	0		0	39,431			
	C - HOUSEKEEPING						
1.00	HOUSEKEEPING	9.00	33,768	0	0		1.00
	0		33,768	0			
	D - DRUGS						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	973	0		1.00
2.00	PHARMACY	15.00	0	2,761,726	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	169	0		3.00
4.00	OPERATING ROOM	50.00	0	3,167	0		4.00
5.00	RADIOLOGY-DIAGNOSTIC	54.00	0	36,139	0		5.00
6.00	LABORATORY	60.00	0	297	0		6.00
7.00	PHYSICAL THERAPY	66.00	0	279	0		7.00
8.00	PHYSICAL THERAPY- WHEATFIELD	66.01	0	1,260	0		8.00
9.00	RURAL HEALTH CLINIC	88.00	0	11,228	0		9.00
10.00	RURAL HEALTH CLINIC II	88.01	0	15,609	0		10.00
11.00	CLINIC	90.00	0	58	0		11.00
12.00	WOUND CARE	90.01	0	445	0		12.00
13.00	EMERGENCY	91.00	0	1,284	0		13.00
	0		0	2,832,634			
500.00	Grand Total: Decreases		203,987	2,967,739			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1324 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-7 Part I | Date/Time Prepared: 5/29/2023 3:36 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	675,791	0	0	0	0	1.00
2.00	Land Improvements	484,426	25,500	0	25,500	0	2.00
3.00	Buildings and Fixtures	17,403,786	2,694,886	0	2,694,886	0	3.00
4.00	Building Improvements	1,808,886	0	0	0	1,808,886	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	12,722,058	0	0	0	1,021,325	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	33,094,947	2,720,386	0	2,720,386	2,830,211	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	33,094,947	2,720,386	0	2,720,386	2,830,211	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	675,791	0	1.00
2.00	Land Improvements	509,926	0	2.00
3.00	Buildings and Fixtures	20,098,672	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	11,700,733	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	32,985,122	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	32,985,122	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1324 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-7 Part II | Date/Time Prepared: 5/29/2023 3:36 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	2,690,406	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	2,690,406	0	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	2,690,406		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		2.00
3.00	Total (sum of lines 1-2)	0	2,690,406		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1324 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-7 Part III Date/Time Prepared: 5/29/2023 3:36 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	21,284,389	0	21,284,389	0.645272	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	11,700,733	0	11,700,733	0.354728	0	2.00
3.00	Total (sum of lines 1-2)	32,985,122	0	32,985,122	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	2,698,845	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	2,698,845	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	10,296	39,431	0	278,467	3,027,039	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	10,296	39,431	0	278,467	3,027,039	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1324 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-8 | Date/Time Prepared: 5/29/2023 3:36 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)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)	B	-114,147	CENTRAL SERVICES & SUPPLY	14.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-1,190,488			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	143,843			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-73,503	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines	B	-1,935	CAFETERIA	11.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	HAF OFFSET	A	-1,528,997	ADMINISTRATIVE & GENERAL	5.00	0	33.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1324 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-8 | Date/Time Prepared: 5/29/2023 3:36 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	
34.00	OTHER REVENUE	B	-14,687	ADMINISTRATIVE & GENERAL	5.00	0	34.00
34.01	OTHER REVENUE	B	-7,070	RURAL HEALTH CLINIC	88.00	0	34.01
35.00	LOBBYING	A	-734	ADMINISTRATIVE & GENERAL	5.00	0	35.00
36.00	DEPRECIATION CARRYFORWARD	A	8,439	CAP REL COSTS-BLDG & FIXT	1.00	9	36.00
37.00	MARKETING / ADVERTISING	A	-1,467	ADMINISTRATIVE & GENERAL	5.00	0	37.00
38.00	MARKETING / ADVERTISING	A	-7,780	OPERATION OF PLANT	7.00	0	38.00
38.01	MARKETING / ADVERTISING	A	-33	ADULTS & PEDIATRICS	30.00	0	38.01
38.02	MARKETING / ADVERTISING	A	-38	OPERATING ROOM	50.00	0	38.02
38.03	MARKETING / ADVERTISING	A	-2,714	RADIOLOGY-DIAGNOSTIC	54.00	0	38.03
38.04	MARKETING / ADVERTISING	A	-1,808	PHYSICAL THERAPY	66.00	0	38.04
38.05	MARKETING / ADVERTISING	A	-510	OCCUPATIONAL THERAPY	67.00	0	38.05
38.06	MARKETING / ADVERTISING	A	-43	RURAL HEALTH CLINIC	88.00	0	38.06
38.07	MARKETING / ADVERTISING	A	-407	RURAL HEALTH CLINIC II	88.01	0	38.07
38.08	MARKETING / ADVERTISING	A	-300	CLINIC	90.00	0	38.08
38.09	MARKETING / ADVERTISING	A	-33	EMERGENCY	91.00	0	38.09
39.00	PHYSICIAN RHC SALARY	A	-7,606	RURAL HEALTH CLINIC	88.00	0	39.00
39.01	PHYSICIAN RHC SALARY	A	-35,639	RURAL HEALTH CLINIC II	88.01	0	39.01
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-2,837,657				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: 15-1324 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-8-1 | Date/Time Prepared: 5/29/2023 3:36 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	1.00	CAP REL COSTS-BLDG & FIXT	ALLOWABLE NEW CAPITAL COSTS	278,467	0	1.00
2.00	1.00	CAP REL COSTS-BLDG & FIXT	INTEREST	10,296	0	2.00
3.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	EMPLYEE BENEFITS	0	871,243	3.00
3.02	5.00	ADMINISTRATIVE & GENERAL	ADMIN & GENERAL	5,339,945	6,371,285	3.02
4.00	15.00	PHARMACY	COVP/PHARMACY	30,142	0	4.00
4.01	16.00	MEDICAL RECORDS & LIBRARY	MEDICAL RECORDS	417,617	0	4.01
4.02	4.00	EMPLOYEE BENEFITS DEPARTMENT	SHARED SERVICES	58,785	0	4.02
4.03	5.00	ADMINISTRATIVE & GENERAL	SHARED SERVICES	1,008,244	0	4.03
4.04	13.00	NURSING ADMINISTRATION	SHARED SERVICES	223,303	0	4.04
4.05	15.00	PHARMACY	SHARED SERVICES	19,572	0	4.05
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			7,386,371	7,242,528	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	B	FRANCISCAN ALLI	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: 15-1324 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-8-1 | Date/Time Prepared: 5/29/2023 3:36 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	278,467	14		1.00
2.00	10,296	11		2.00
3.00	-871,243	0		3.00
3.02	-1,031,340	0		3.02
4.00	30,142	0		4.00
4.01	417,617	0		4.01
4.02	58,785	0		4.02
4.03	1,008,244	0		4.03
4.04	223,303	0		4.04
4.05	19,572	0		4.05
5.00	143,843			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: 15-1324 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-8-2 | Date/Time Prepared: 5/29/2023 3:36 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	5.00	ADMINISTRATIVE & GENERAL	52,601	0	52,601	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	531,055	531,055	0	0	0	2.00
3.00	50.00	OPERATING ROOM	220,017	220,017	0	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	26,124	26,124	0	0	0	4.00
5.00	65.00	RESPIRATORY THERAPY	9,769	9,769	0	0	0	5.00
6.00	90.00	CLINIC	403,523	403,523	0	0	0	6.00
7.00	91.00	EMERGENCY	981,755	0	981,755	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			2,224,844	1,190,488	1,034,356		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	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	50.00	OPERATING ROOM	0	0	0	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	4.00
5.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	5.00
6.00	90.00	CLINIC	0	0	0	0	0	6.00
7.00	91.00	EMERGENCY	0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	531,055		2.00
3.00	50.00	OPERATING ROOM	0	0	0	220,017		3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	26,124		4.00
5.00	65.00	RESPIRATORY THERAPY	0	0	0	9,769		5.00
6.00	90.00	CLINIC	0	0	0	403,523		6.00
7.00	91.00	EMERGENCY	0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	1,190,488		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1324 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part I | Date/Time Prepared: 5/29/2023 3:36 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	3,027,039	3,027,039				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0		0			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,513,333	58,169	0	2,571,502		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	9,327,681	304,467	0	800,684	10,432,832	5.00
7.00	00700	OPERATION OF PLANT	1,713,307	345,687	0	74,022	2,133,016	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	18,712	36,938	0	3,072	58,722	8.00
9.00	00900	HOUSEKEEPING	501,779	41,455	0	70,900	614,134	9.00
10.00	01000	DIETARY	147,544	40,940	0	17,056	205,540	10.00
11.00	01100	CAFETERIA	190,455	54,400	0	30,737	275,592	11.00
13.00	01300	NURSING ADMINISTRATION	478,115	9,340	0	25,926	513,381	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-40,585	100,584	0	2,609	62,608	14.00
15.00	01500	PHARMACY	429,956	25,632	0	58,264	513,852	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	417,617	37,663	0	0	455,280	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,762,683	219,660	0	354,869	2,337,212	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
32.00	03200	CORONARY CARE UNIT	0	0	0	0	0	32.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	762,684	214,018	0	117,711	1,094,413	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,418,915	121,510	0	195,777	1,736,202	54.00
60.00	06000	LABORATORY	2,513,931	66,198	0	0	2,580,129	60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	7,471	2,388	0	0	9,859	63.00
65.00	06500	RESPIRATORY THERAPY	711,184	88,271	0	119,700	919,155	65.00
66.00	06600	PHYSICAL THERAPY	514,361	49,765	0	87,600	651,726	66.00
66.01	06601	PHYSICAL THERAPY- WHEATFIELD	285,185	220,947	0	50,175	556,307	66.01
67.00	06700	OCCUPATIONAL THERAPY	139,539	10,089	0	24,588	174,216	67.00
67.01	06701	OCCUPATIONAL THERAPY- WHEATFIELD	83,057	46,114	0	14,253	143,424	67.01
68.00	06800	SPEECH PATHOLOGY	100,451	8,544	0	17,786	126,781	68.00
68.01	06801	SPEECH PATHOLOGY- WHEATFIELD	147,953	29,915	0	25,798	203,666	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	694,760	0	0	0	694,760	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	143,687	0	0	0	143,687	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,832,634	0	0	0	2,832,634	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	251,424	0	0	42,794	294,218	88.00
88.01	08801	RURAL HEALTH CLINIC II	256,083	60,205	0	49,984	366,272	88.01
90.00	09000	CLINIC	953,222	302,570	0	159,202	1,414,994	90.00
90.01	09001	WOUND CARE	17,272	23,150	0	2,565	42,987	90.01
91.00	09100	EMERGENCY	2,565,615	183,214	0	225,430	2,974,259	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	34,887,064	2,701,833	0	2,571,502	34,561,858	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	1,673	6,437	0	0	8,110	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	72	0	0	0	72	192.00
194.00	07950	ALTERNACARE	175	0	0	0	175	194.00
194.01	07951	SPORTS MEDICINE	85	0	0	0	85	194.01
194.02	07952	UNUSED SPACE	0	318,769	0	0	318,769	194.02
194.03	07953	LAFAYETTE HHA BRANCH	0	0	0	0	0	194.03
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)	34,889,069	3,027,039	0	2,571,502	34,889,069	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1324 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part I Date/Time Prepared: 5/29/2023 3:36 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	10,432,832					5.00
7.00	00700	OPERATION OF PLANT	909,928	3,042,944				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	25,050	48,475	132,247			8.00
9.00	00900	HOUSEKEEPING	261,985	54,404	4,735	935,258		9.00
10.00	01000	DIETARY	87,682	53,728	0	17,091	364,041	10.00
11.00	01100	CAFETERIA	117,565	71,391	1,487	22,710	0	11.00
13.00	01300	NURSING ADMINISTRATION	219,004	12,257	0	3,899	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	26,708	132,000	0	41,990	0	14.00
15.00	01500	PHARMACY	219,205	33,637	0	10,700	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	194,219	49,427	0	15,723	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	997,036	288,268	26,929	91,700	364,041	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
32.00	03200	CORONARY CARE UNIT	0	0	0	0	0	32.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	466,868	280,865	6,234	89,345	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	740,650	159,463	19,222	50,726	0	54.00
60.00	06000	LABORATORY	1,100,662	86,874	0	27,635	0	60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	4,206	3,133	0	997	0	63.00
65.00	06500	RESPIRATORY THERAPY	392,104	115,842	4,753	36,850	0	65.00
66.00	06600	PHYSICAL THERAPY	278,021	65,309	6,238	20,775	0	66.00
66.01	06601	PHYSICAL THERAPY- WHEATFIELD	237,316	289,958	0	92,238	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	74,319	13,240	0	4,212	0	67.00
67.01	06701	OCCUPATIONAL THERAPY- WHEATFIELD	61,184	60,517	0	19,251	0	67.01
68.00	06800	SPEECH PATHOLOGY	54,084	11,212	0	3,567	0	68.00
68.01	06801	SPEECH PATHOLOGY- WHEATFIELD	86,882	39,259	0	12,489	0	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	296,379	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	61,296	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,208,379	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	125,511	0	14,716	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	156,249	79,010	0	25,134	0	88.01
90.00	09000	CLINIC	603,625	397,075	8,329	126,313	0	90.00
90.01	09001	WOUND CARE	18,338	30,381	0	9,665	0	90.01
91.00	09100	EMERGENCY	1,268,791	240,439	39,604	76,485	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	10,293,246	2,616,164	132,247	799,495	364,041	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	3,460	8,448	0	2,687	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	31	0	0	0	0	192.00
194.00	07950	ALTERNACARE	75	0	0	0	0	194.00
194.01	07951	SPORTS MEDICINE	36	0	0	0	0	194.01
194.02	07952	UNUSED SPACE	135,984	418,332	0	133,076	0	194.02
194.03	07953	LAFAYETTE HHA BRANCH	0	0	0	0	0	194.03
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)	10,432,832	3,042,944	132,247	935,258	364,041	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1324 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part I | Date/Time Prepared: 5/29/2023 3:36 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	488,745					11.00
13.00	01300	NURSING ADMINISTRATION	9,109	757,650				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	917	0	264,223			14.00
15.00	01500	PHARMACY	20,470	0	0	797,864		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	714,649	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	124,680	251,859	0	48	32,715	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
32.00	03200	CORONARY CARE UNIT	0	0	0	0	0	32.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	41,032	83,990	0	892	20,960	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	68,783	82,629	0	10,179	117,874	54.00
60.00	06000	LABORATORY	0	0	0	84	103,009	60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	0	0	0	0	1,060	63.00
65.00	06500	RESPIRATORY THERAPY	42,055	0	0	0	22,419	65.00
66.00	06600	PHYSICAL THERAPY	30,777	0	0	79	20,149	66.00
66.01	06601	PHYSICAL THERAPY- WHEATFIELD	0	0	0	355	13,280	66.01
67.00	06700	OCCUPATIONAL THERAPY	8,638	0	0	0	4,322	67.00
67.01	06701	OCCUPATIONAL THERAPY- WHEATFIELD	0	0	0	0	1,770	67.01
68.00	06800	SPEECH PATHOLOGY	6,249	0	0	0	1,929	68.00
68.01	06801	SPEECH PATHOLOGY- WHEATFIELD	0	0	0	0	3,842	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	218,942	274	33,875	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	45,281	0	12,400	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	777,885	225,504	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	3,163	1,163	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	4,397	1,980	88.01
90.00	09000	CLINIC	55,933	139,327	0	16	34,165	90.00
90.01	09001	WOUND CARE	901	0	0	125	1,542	90.01
91.00	09100	EMERGENCY	79,201	199,845	0	362	60,691	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	488,745	757,650	264,223	797,859	714,649	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	5	0	192.00
194.00	07950	ALTERNACARE	0	0	0	0	0	194.00
194.01	07951	SPORTS MEDICINE	0	0	0	0	0	194.01
194.02	07952	UNUSED SPACE	0	0	0	0	0	194.02
194.03	07953	LAFAYETTE HHA BRANCH	0	0	0	0	0	194.03
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)	488,745	757,650	264,223	797,864	714,649	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1324 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part I | Date/Time Prepared: 5/29/2023 3:36 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	4,514,488	0	4,514,488		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0		31.00
32.00	03200	CORONARY CARE UNIT	0	0	0		32.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	2,084,599	0	2,084,599		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,985,728	0	2,985,728		54.00
60.00	06000	LABORATORY	3,898,393	0	3,898,393		60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	19,255	0	19,255		63.00
65.00	06500	RESPIRATORY THERAPY	1,533,178	0	1,533,178		65.00
66.00	06600	PHYSICAL THERAPY	1,073,074	0	1,073,074		66.00
66.01	06601	PHYSICAL THERAPY- WHEATFIELD	1,189,454	0	1,189,454		66.01
67.00	06700	OCCUPATIONAL THERAPY	278,947	0	278,947		67.00
67.01	06701	OCCUPATIONAL THERAPY- WHEATFIELD	286,146	0	286,146		67.01
68.00	06800	SPEECH PATHOLOGY	203,822	0	203,822		68.00
68.01	06801	SPEECH PATHOLOGY- WHEATFIELD	346,138	0	346,138		68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,244,230	0	1,244,230		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	262,664	0	262,664		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,044,402	0	5,044,402		73.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	438,771	0	438,771		88.00
88.01	08801	RURAL HEALTH CLINIC II	633,042	0	633,042		88.01
90.00	09000	CLINIC	2,779,777	0	2,779,777		90.00
90.01	09001	WOUND CARE	103,939	0	103,939		90.01
91.00	09100	EMERGENCY	4,939,677	0	4,939,677		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	0	0		95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0		101.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0		115.00
116.00	11600	HOSPICE	0	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	33,859,724	0	33,859,724		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	22,705	0	22,705		190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	108	0	108		192.00
194.00	07950	ALTERNACARE	250	0	250		194.00
194.01	07951	SPORTS MEDICINE	121	0	121		194.01
194.02	07952	UNUSED SPACE	1,006,161	0	1,006,161		194.02
194.03	07953	LAFAYETTE HHA BRANCH	0	0	0		194.03
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)	34,889,069	0	34,889,069		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1324 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part II Date/Time Prepared: 5/29/2023 3:36 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	58,169	0	58,169	58,169	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	304,467	0	304,467	18,107	5.00
7.00	00700	OPERATION OF PLANT	0	345,687	0	345,687	1,675	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	36,938	0	36,938	70	8.00
9.00	00900	HOUSEKEEPING	0	41,455	0	41,455	1,604	9.00
10.00	01000	DIETARY	0	40,940	0	40,940	386	10.00
11.00	01100	CAFETERIA	0	54,400	0	54,400	695	11.00
13.00	01300	NURSING ADMINISTRATION	0	9,340	0	9,340	587	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	100,584	0	100,584	59	14.00
15.00	01500	PHARMACY	0	25,632	0	25,632	1,318	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	37,663	0	37,663	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	219,660	0	219,660	8,028	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
32.00	03200	CORONARY CARE UNIT	0	0	0	0	0	32.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	214,018	0	214,018	2,663	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	121,510	0	121,510	4,429	54.00
60.00	06000	LABORATORY	0	66,198	0	66,198	0	60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	0	2,388	0	2,388	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	88,271	0	88,271	2,708	65.00
66.00	06600	PHYSICAL THERAPY	0	49,765	0	49,765	1,982	66.00
66.01	06601	PHYSICAL THERAPY- WHEATFIELD	0	220,947	0	220,947	1,135	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	10,089	0	10,089	556	67.00
67.01	06701	OCCUPATIONAL THERAPY- WHEATFIELD	0	46,114	0	46,114	322	67.01
68.00	06800	SPEECH PATHOLOGY	0	8,544	0	8,544	402	68.00
68.01	06801	SPEECH PATHOLOGY- WHEATFIELD	0	29,915	0	29,915	584	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	968	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	60,205	0	60,205	1,131	88.01
90.00	09000	CLINIC	0	302,570	0	302,570	3,602	90.00
90.01	09001	WOUND CARE	0	23,150	0	23,150	58	90.01
91.00	09100	EMERGENCY	0	183,214	0	183,214	5,100	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	2,701,833	0	2,701,833	58,169	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	6,437	0	6,437	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	ALTERNACARE	0	0	0	0	0	194.00
194.01	07951	SPORTS MEDICINE	0	0	0	0	0	194.01
194.02	07952	UNUSED SPACE	0	318,769	0	318,769	0	194.02
194.03	07953	LAFAYETTE HHA BRANCH	0	0	0	0	0	194.03
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	3,027,039	0	3,027,039	58,169	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1324 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part II Date/Time Prepared: 5/29/2023 3:36 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	322,574					5.00
7.00	00700	OPERATION OF PLANT	28,134	375,496				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	775	5,982	43,765			8.00
9.00	00900	HOUSEKEEPING	8,100	6,713	1,567	59,439		9.00
10.00	01000	DIETARY	2,711	6,630	0	1,086	51,753	10.00
11.00	01100	CAFETERIA	3,635	8,810	492	1,443	0	11.00
13.00	01300	NURSING ADMINISTRATION	6,771	1,512	0	248	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	826	16,289	0	2,669	0	14.00
15.00	01500	PHARMACY	6,778	4,151	0	680	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	6,005	6,099	0	999	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	30,828	35,572	8,912	5,828	51,753	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
32.00	03200	CORONARY CARE UNIT	0	0	0	0	0	32.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	14,435	34,658	2,063	5,678	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	22,901	19,678	6,361	3,224	0	54.00
60.00	06000	LABORATORY	34,032	10,720	0	1,756	0	60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	130	387	0	63	0	63.00
65.00	06500	RESPIRATORY THERAPY	12,124	14,295	1,573	2,342	0	65.00
66.00	06600	PHYSICAL THERAPY	8,596	8,059	2,064	1,320	0	66.00
66.01	06601	PHYSICAL THERAPY- WHEATFIELD	7,338	35,780	0	5,862	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	2,298	1,634	0	268	0	67.00
67.01	06701	OCCUPATIONAL THERAPY- WHEATFIELD	1,892	7,468	0	1,223	0	67.01
68.00	06800	SPEECH PATHOLOGY	1,672	1,384	0	227	0	68.00
68.01	06801	SPEECH PATHOLOGY- WHEATFIELD	2,686	4,845	0	794	0	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	9,164	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,895	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	37,362	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	3,881	0	4,870	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	4,831	9,750	0	1,597	0	88.01
90.00	09000	CLINIC	18,664	48,999	2,756	8,028	0	90.00
90.01	09001	WOUND CARE	567	3,749	0	614	0	90.01
91.00	09100	EMERGENCY	39,227	29,670	13,107	4,861	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	318,258	322,834	43,765	50,810	51,753	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	107	1,042	0	171	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	1	0	0	0	0	192.00
194.00	07950	ALTERNACARE	2	0	0	0	0	194.00
194.01	07951	SPORTS MEDICINE	1	0	0	0	0	194.01
194.02	07952	UNUSED SPACE	4,205	51,620	0	8,458	0	194.02
194.03	07953	LAFAYETTE HHA BRANCH	0	0	0	0	0	194.03
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)	322,574	375,496	43,765	59,439	51,753	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1324 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part II | Date/Time Prepared: 5/29/2023 3:36 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	69,475					11.00
13.00	01300	NURSING ADMINISTRATION	1,295	19,753				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	130	0	104,505			14.00
15.00	01500	PHARMACY	2,910	0	0	41,469		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	50,766	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	17,724	6,567	0	2	2,324	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
32.00	03200	CORONARY CARE UNIT	0	0	0	0	0	32.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,833	2,190	0	46	1,489	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,777	2,154	0	529	8,373	54.00
60.00	06000	LABORATORY	0	0	0	4	7,317	60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	0	0	0	0	75	63.00
65.00	06500	RESPIRATORY THERAPY	5,978	0	0	0	1,593	65.00
66.00	06600	PHYSICAL THERAPY	4,375	0	0	4	1,431	66.00
66.01	06601	PHYSICAL THERAPY- WHEATFIELD	0	0	0	18	943	66.01
67.00	06700	OCCUPATIONAL THERAPY	1,228	0	0	0	307	67.00
67.01	06701	OCCUPATIONAL THERAPY- WHEATFIELD	0	0	0	0	126	67.01
68.00	06800	SPEECH PATHOLOGY	888	0	0	0	137	68.00
68.01	06801	SPEECH PATHOLOGY- WHEATFIELD	0	0	0	0	273	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	86,596	14	2,406	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	17,909	0	881	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	40,432	16,019	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	164	83	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	229	141	88.01
90.00	09000	CLINIC	7,951	3,632	0	1	2,427	90.00
90.01	09001	WOUND CARE	128	0	0	7	110	90.01
91.00	09100	EMERGENCY	11,258	5,210	0	19	4,311	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	69,475	19,753	104,505	41,469	50,766	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	ALTERNACARE	0	0	0	0	0	194.00
194.01	07951	SPORTS MEDICINE	0	0	0	0	0	194.01
194.02	07952	UNUSED SPACE	0	0	0	0	0	194.02
194.03	07953	LAFAYETTE HHA BRANCH	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	16,052	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	69,475	19,753	120,557	41,469	50,766	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1324 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part II | Date/Time Prepared: 5/29/2023 3:36 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	387,198	0	387,198		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0		31.00
32.00	03200	CORONARY CARE UNIT	0	0	0		32.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	283,073	0	283,073		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	198,936	0	198,936		54.00
60.00	06000	LABORATORY	120,027	0	120,027		60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	3,043	0	3,043		63.00
65.00	06500	RESPIRATORY THERAPY	128,884	0	128,884		65.00
66.00	06600	PHYSICAL THERAPY	77,596	0	77,596		66.00
66.01	06601	PHYSICAL THERAPY- WHEATFIELD	272,023	0	272,023		66.01
67.00	06700	OCCUPATIONAL THERAPY	16,380	0	16,380		67.00
67.01	06701	OCCUPATIONAL THERAPY- WHEATFIELD	57,145	0	57,145		67.01
68.00	06800	SPEECH PATHOLOGY	13,254	0	13,254		68.00
68.01	06801	SPEECH PATHOLOGY- WHEATFIELD	39,097	0	39,097		68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	98,180	0	98,180		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	20,685	0	20,685		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	93,813	0	93,813		73.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	9,966	0	9,966		88.00
88.01	08801	RURAL HEALTH CLINIC II	77,884	0	77,884		88.01
90.00	09000	CLINIC	398,630	0	398,630		90.00
90.01	09001	WOUND CARE	28,383	0	28,383		90.01
91.00	09100	EMERGENCY	295,977	0	295,977		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	0	0		95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0		101.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0		115.00
116.00	11600	HOSPICE	0	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,620,174	0	2,620,174		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	7,757	0	7,757		190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	1	0	1		192.00
194.00	07950	ALTERNACARE	2	0	2		194.00
194.01	07951	SPORTS MEDICINE	1	0	1		194.01
194.02	07952	UNUSED SPACE	383,052	0	383,052		194.02
194.03	07953	LAFAYETTE HHA BRANCH	0	0	0		194.03
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	16,052	0	16,052		201.00
202.00		TOTAL (sum lines 118 through 201)	3,027,039	0	3,027,039		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1324 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B-1 | Date/Time Prepared: 5/29/2023 3:36 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	129,317					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		129,317				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,485	2,485	14,240,894			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	13,007	13,007	4,434,186	-10,432,832	24,456,237	5.00
7.00	00700	OPERATION OF PLANT	14,768	14,768	409,933	0	2,133,016	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,578	1,578	17,014	0	58,722	8.00
9.00	00900	HOUSEKEEPING	1,771	1,771	392,639	0	614,134	9.00
10.00	01000	DIETARY	1,749	1,749	94,454	0	205,540	10.00
11.00	01100	CAFETERIA	2,324	2,324	170,219	0	275,592	11.00
13.00	01300	NURSING ADMINISTRATION	399	399	143,579	0	513,381	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	4,297	4,297	14,450	0	62,608	14.00
15.00	01500	PHARMACY	1,095	1,095	322,664	0	513,852	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,609	1,609	0	0	455,280	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,384	9,384	1,965,250	0	2,337,212	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
32.00	03200	CORONARY CARE UNIT	0	0	0	0	0	32.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	9,143	9,143	651,876	0	1,094,413	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,191	5,191	1,084,206	0	1,736,202	54.00
60.00	06000	LABORATORY	2,828	2,828	0	0	2,580,129	60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	102	102	0	0	9,859	63.00
65.00	06500	RESPIRATORY THERAPY	3,771	3,771	662,893	0	919,155	65.00
66.00	06600	PHYSICAL THERAPY	2,126	2,126	485,123	0	651,726	66.00
66.01	06601	PHYSICAL THERAPY- WHEATFIELD	9,439	9,439	277,868	0	556,307	66.01
67.00	06700	OCCUPATIONAL THERAPY	431	431	136,165	0	174,216	67.00
67.01	06701	OCCUPATIONAL THERAPY- WHEATFIELD	1,970	1,970	78,931	0	143,424	67.01
68.00	06800	SPEECH PATHOLOGY	365	365	98,498	0	126,781	68.00
68.01	06801	SPEECH PATHOLOGY- WHEATFIELD	1,278	1,278	142,869	0	203,666	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	694,760	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	143,687	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	2,832,634	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	236,990	0	294,218	88.00
88.01	08801	RURAL HEALTH CLINIC II	2,572	2,572	276,810	0	366,272	88.01
90.00	09000	CLINIC	12,926	12,926	881,654	0	1,414,994	90.00
90.01	09001	WOUND CARE	989	989	14,204	0	42,987	90.01
91.00	09100	EMERGENCY	7,827	7,827	1,248,419	0	2,974,259	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	115,424	115,424	14,240,894	-10,432,832	24,129,026	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	275	275	0	0	8,110	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	72	192.00
194.00	07950	ALTERNACARE	0	0	0	0	175	194.00
194.01	07951	SPORTS MEDICINE	0	0	0	0	85	194.01
194.02	07952	UNUSED SPACE	13,618	13,618	0	0	318,769	194.02
194.03	07953	LAFAYETTE HHA BRANCH	0	0	0	0	0	194.03
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)	3,027,039	0	2,571,502		10,432,832	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	23.407897	0.000000	0.180572		0.426592	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			58,169		322,574	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.004085		0.013190	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: 15-1324 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B-1 | Date/Time Prepared: 5/29/2023 3:36 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (SALARIES)	
			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	99,057					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,578	175,720				8.00
9.00	00900	HOUSEKEEPING	1,771	6,292	95,708			9.00
10.00	01000	DIETARY	1,749	0	1,749	13,767		10.00
11.00	01100	CAFETERIA	2,324	1,976	2,324	0	7,703,872	11.00
13.00	01300	NURSING ADMINISTRATION	399	0	399	0	143,579	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	4,297	0	4,297	0	14,450	14.00
15.00	01500	PHARMACY	1,095	0	1,095	0	322,664	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,609	0	1,609	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,384	35,781	9,384	13,767	1,965,250	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
32.00	03200	CORONARY CARE UNIT	0	0	0	0	0	32.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	9,143	8,283	9,143	0	646,767	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,191	25,541	5,191	0	1,084,206	54.00
60.00	06000	LABORATORY	2,828	0	2,828	0	0	60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	102	0	102	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	3,771	6,316	3,771	0	662,893	65.00
66.00	06600	PHYSICAL THERAPY	2,126	8,289	2,126	0	485,123	66.00
66.01	06601	PHYSICAL THERAPY- WHEATFIELD	9,439	0	9,439	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	431	0	431	0	136,165	67.00
67.01	06701	OCCUPATIONAL THERAPY- WHEATFIELD	1,970	0	1,970	0	0	67.01
68.00	06800	SPEECH PATHOLOGY	365	0	365	0	98,498	68.00
68.01	06801	SPEECH PATHOLOGY- WHEATFIELD	1,278	0	1,278	0	0	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	19,553	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	2,572	0	2,572	0	0	88.01
90.00	09000	CLINIC	12,926	11,067	12,926	0	881,654	90.00
90.01	09001	WOUND CARE	989	0	989	0	14,204	90.01
91.00	09100	EMERGENCY	7,827	52,622	7,827	0	1,248,419	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	85,164	175,720	81,815	13,767	7,703,872	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	275	0	275	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	ALTERNACARE	0	0	0	0	0	194.00
194.01	07951	SPORTS MEDICINE	0	0	0	0	0	194.01
194.02	07952	UNUSED SPACE	13,618	0	13,618	0	0	194.02
194.03	07953	LAFAYETTE HHA BRANCH	0	0	0	0	0	194.03
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)	3,042,944	132,247	935,258	364,041	488,745	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	30.719121	0.752601	9.771994	26.443016	0.063441	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	375,496	43,765	59,439	51,753	69,475	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	3.790706	0.249061	0.621045	3.759207	0.009018	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: 15-1324 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B-1 | Date/Time Prepared: 5/29/2023 3:36 pm

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)		
			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	120,787					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	838,447				14.00
15.00	01500	PHARMACY	0	0	2,832,654			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	100,335,320		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	40,152	0	169	4,592,849		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0		31.00
32.00	03200	CORONARY CARE UNIT	0	0	0	0		32.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	13,390	0	3,167	2,942,566		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	13,173	0	36,139	16,548,395		54.00
60.00	06000	LABORATORY	0	0	297	14,461,403		60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	0	0	0	148,801		63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	3,147,459		65.00
66.00	06600	PHYSICAL THERAPY	0	0	279	2,828,718		66.00
66.01	06601	PHYSICAL THERAPY- WHEATFIELD	0	0	1,260	1,864,358		66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	606,757		67.00
67.01	06701	OCCUPATIONAL THERAPY- WHEATFIELD	0	0	0	248,507		67.01
68.00	06800	SPEECH PATHOLOGY	0	0	0	270,870		68.00
68.01	06801	SPEECH PATHOLOGY- WHEATFIELD	0	0	0	539,320		68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	694,760	973	4,755,760		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	143,687	0	1,740,822		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	2,761,727	31,663,973		73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	11,228	163,280		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	15,609	277,985		88.01
90.00	09000	CLINIC	22,212	0	58	4,796,478		90.00
90.01	09001	WOUND CARE	0	0	445	216,545		90.01
91.00	09100	EMERGENCY	31,860	0	1,284	8,520,474		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0		95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0		101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0		115.00
116.00	11600	HOSPICE	0	0	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	120,787	838,447	2,832,635	100,335,320		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	19	0		192.00
194.00	07950	ALTERNACARE	0	0	0	0		194.00
194.01	07951	SPORTS MEDICINE	0	0	0	0		194.01
194.02	07952	UNUSED SPACE	0	0	0	0		194.02
194.03	07953	LAFAYETTE HHA BRANCH	0	0	0	0		194.03
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)	757,650	264,223	797,864	714,649		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	6.272612	0.315134	0.281667	0.007123		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	19,753	120,557	41,469	50,766		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.163536	0.124641	0.014640	0.000506		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: 15-1324 | Period: From 01/01/2022 To 12/31/2022 | Worksheet C Part I Date/Time Prepared: 5/29/2023 3:36 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,514,488		4,514,488	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0		0	0	0	31.00
32.00	03200	CORONARY CARE UNIT	0		0	0	0	32.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,084,599		2,084,599	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,985,728		2,985,728	0	0	54.00
60.00	06000	LABORATORY	3,898,393		3,898,393	0	0	60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	19,255		19,255	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	1,533,178	0	1,533,178	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,073,074	0	1,073,074	0	0	66.00
66.01	06601	PHYSICAL THERAPY- WHEATFIELD	1,189,454	0	1,189,454	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	278,947	0	278,947	0	0	67.00
67.01	06701	OCCUPATIONAL THERAPY- WHEATFIELD	286,146	0	286,146	0	0	67.01
68.00	06800	SPEECH PATHOLOGY	203,822	0	203,822	0	0	68.00
68.01	06801	SPEECH PATHOLOGY- WHEATFIELD	346,138	0	346,138	0	0	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,244,230		1,244,230	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	262,664		262,664	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,044,402		5,044,402	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	438,771		438,771	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	633,042		633,042	0	0	88.01
90.00	09000	CLINIC	2,779,777		2,779,777	0	0	90.00
90.01	09001	WOUND CARE	103,939		103,939	0	0	90.01
91.00	09100	EMERGENCY	4,939,677		4,939,677	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,184,198		1,184,198		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0		0		0	115.00
116.00	11600	HOSPICE	0		0		0	116.00
200.00		Subtotal (see instructions)	35,043,922	0	35,043,922	0	0	200.00
201.00		Less Observation Beds	1,184,198		1,184,198		0	201.00
202.00		Total (see instructions)	33,859,724	0	33,859,724	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1324 | Period: From 01/01/2022 To 12/31/2022 | Worksheet C Part I Date/Time Prepared: 5/29/2023 3:36 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	2,458,439		2,458,439			30.00
31.00	03100	INTENSIVE CARE UNIT	0		0			31.00
32.00	03200	CORONARY CARE UNIT	0		0			32.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	99,161	2,843,405	2,942,566	0.708429	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	486,598	16,061,797	16,548,395	0.180424	0.000000	54.00
60.00	06000	LABORATORY	1,099,956	13,361,447	14,461,403	0.269572	0.000000	60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	26,606	122,195	148,801	0.129401	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	381,817	2,765,642	3,147,459	0.487116	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	220,406	2,608,312	2,828,718	0.379350	0.000000	66.00
66.01	06601	PHYSICAL THERAPY- WHEATFIELD	0	1,864,358	1,864,358	0.637997	0.000000	66.01
67.00	06700	OCCUPATIONAL THERAPY	211,160	395,597	606,757	0.459734	0.000000	67.00
67.01	06701	OCCUPATIONAL THERAPY- WHEATFIELD	216	248,291	248,507	1.151461	0.000000	67.01
68.00	06800	SPEECH PATHOLOGY	21,559	249,311	270,870	0.752472	0.000000	68.00
68.01	06801	SPEECH PATHOLOGY- WHEATFIELD	0	539,320	539,320	0.641804	0.000000	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	344,908	4,410,852	4,755,760	0.261626	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	169,037	1,571,785	1,740,822	0.150885	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,250,348	30,413,625	31,663,973	0.159310	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	163,280	163,280			88.00
88.01	08801	RURAL HEALTH CLINIC II	0	277,985	277,985			88.01
90.00	09000	CLINIC	421	4,796,057	4,796,478	0.579545	0.000000	90.00
90.01	09001	WOUND CARE	0	216,545	216,545	0.479988	0.000000	90.01
91.00	09100	EMERGENCY	237,774	8,282,700	8,520,474	0.579742	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	43,000	2,091,410	2,134,410	0.554813	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0			115.00
116.00	11600	HOSPICE	0	0	0			116.00
200.00		Subtotal (see instructions)	7,051,406	93,283,914	100,335,320			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	7,051,406	93,283,914	100,335,320			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1324 | Period: From 01/01/2022 To 12/31/2022 | Worksheet C Part I Date/Time Prepared: 5/29/2023 3:36 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
32.00	03200	CORONARY CARE UNIT		32.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
60.00	06000	LABORATORY	0.000000	60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
66.01	06601	PHYSICAL THERAPY- WHEATFIELD	0.000000	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
67.01	06701	OCCUPATIONAL THERAPY- WHEATFIELD	0.000000	67.01
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
68.01	06801	SPEECH PATHOLOGY- WHEATFIELD	0.000000	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC		88.00
88.01	08801	RURAL HEALTH CLINIC II		88.01
90.00	09000	CLINIC	0.000000	90.00
90.01	09001	WOUND CARE	0.000000	90.01
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS		
95.00	09500	AMBULANCE SERVICES	0.000000	95.00
101.00	10100	HOME HEALTH AGENCY		101.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)		115.00
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: 15-1324 | Period: From 01/01/2022 To 12/31/2022 | Worksheet C Part I Date/Time Prepared: 5/29/2023 3:36 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,514,488		4,514,488	0	4,514,488	30.00
31.00	03100	INTENSIVE CARE UNIT	0		0	0	0	31.00
32.00	03200	CORONARY CARE UNIT	0		0	0	0	32.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,084,599		2,084,599	0	2,084,599	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,985,728		2,985,728	0	2,985,728	54.00
60.00	06000	LABORATORY	3,898,393		3,898,393	0	3,898,393	60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	19,255		19,255	0	19,255	63.00
65.00	06500	RESPIRATORY THERAPY	1,533,178	0	1,533,178	0	1,533,178	65.00
66.00	06600	PHYSICAL THERAPY	1,073,074	0	1,073,074	0	1,073,074	66.00
66.01	06601	PHYSICAL THERAPY- WHEATFIELD	1,189,454	0	1,189,454	0	1,189,454	66.01
67.00	06700	OCCUPATIONAL THERAPY	278,947	0	278,947	0	278,947	67.00
67.01	06701	OCCUPATIONAL THERAPY- WHEATFIELD	286,146	0	286,146	0	286,146	67.01
68.00	06800	SPEECH PATHOLOGY	203,822	0	203,822	0	203,822	68.00
68.01	06801	SPEECH PATHOLOGY- WHEATFIELD	346,138	0	346,138	0	346,138	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,244,230		1,244,230	0	1,244,230	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	262,664		262,664	0	262,664	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,044,402		5,044,402	0	5,044,402	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	438,771		438,771	0	438,771	88.00
88.01	08801	RURAL HEALTH CLINIC II	633,042		633,042	0	633,042	88.01
90.00	09000	CLINIC	2,779,777		2,779,777	0	2,779,777	90.00
90.01	09001	WOUND CARE	103,939		103,939	0	103,939	90.01
91.00	09100	EMERGENCY	4,939,677		4,939,677	0	4,939,677	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,184,198		1,184,198		1,184,198	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0		0		0	115.00
116.00	11600	HOSPICE	0		0		0	116.00
200.00		Subtotal (see instructions)	35,043,922	0	35,043,922	0	35,043,922	200.00
201.00		Less Observation Beds	1,184,198		1,184,198		1,184,198	201.00
202.00		Total (see instructions)	33,859,724	0	33,859,724	0	33,859,724	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1324 | Period: From 01/01/2022 To 12/31/2022 | Worksheet C Part I Date/Time Prepared: 5/29/2023 3:36 pm

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,458,439		2,458,439			30.00
31.00	03100	INTENSIVE CARE UNIT	0		0			31.00
32.00	03200	CORONARY CARE UNIT	0		0			32.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	99,161	2,843,405	2,942,566	0.708429	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	486,598	16,061,797	16,548,395	0.180424	0.000000	54.00
60.00	06000	LABORATORY	1,099,956	13,361,447	14,461,403	0.269572	0.000000	60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	26,606	122,195	148,801	0.129401	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	381,817	2,765,642	3,147,459	0.487116	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	220,406	2,608,312	2,828,718	0.379350	0.000000	66.00
66.01	06601	PHYSICAL THERAPY- WHEATFIELD	0	1,864,358	1,864,358	0.637997	0.000000	66.01
67.00	06700	OCCUPATIONAL THERAPY	211,160	395,597	606,757	0.459734	0.000000	67.00
67.01	06701	OCCUPATIONAL THERAPY- WHEATFIELD	216	248,291	248,507	1.151461	0.000000	67.01
68.00	06800	SPEECH PATHOLOGY	21,559	249,311	270,870	0.752472	0.000000	68.00
68.01	06801	SPEECH PATHOLOGY- WHEATFIELD	0	539,320	539,320	0.641804	0.000000	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	344,908	4,410,852	4,755,760	0.261626	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	169,037	1,571,785	1,740,822	0.150885	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,250,348	30,413,625	31,663,973	0.159310	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	163,280	163,280	2.687231	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	277,985	277,985	2.277252	0.000000	88.01
90.00	09000	CLINIC	421	4,796,057	4,796,478	0.579545	0.000000	90.00
90.01	09001	WOUND CARE	0	216,545	216,545	0.479988	0.000000	90.01
91.00	09100	EMERGENCY	237,774	8,282,700	8,520,474	0.579742	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	43,000	2,091,410	2,134,410	0.554813	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0			115.00
116.00	11600	HOSPICE	0	0	0			116.00
200.00		Subtotal (see instructions)	7,051,406	93,283,914	100,335,320			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	7,051,406	93,283,914	100,335,320			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1324 | Period: From 01/01/2022 To 12/31/2022 | Worksheet C Part I Date/Time Prepared: 5/29/2023 3:36 pm

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
32.00	03200	CORONARY CARE UNIT			32.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	0.000000		63.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
66.01	06601	PHYSICAL THERAPY- WHEATFIELD	0.000000		66.01
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
67.01	06701	OCCUPATIONAL THERAPY- WHEATFIELD	0.000000		67.01
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
68.01	06801	SPEECH PATHOLOGY- WHEATFIELD	0.000000		68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		88.01
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	WOUND CARE	0.000000		90.01
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
101.00	10100	HOME HEALTH AGENCY			101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)			115.00
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

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-1324 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part II Date/Time Prepared: 5/29/2023 3:36 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	283,073	2,942,566	0.096199	35,357	3,401	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	198,936	16,548,395	0.012021	157,342	1,891	54.00
60.00	06000	LABORATORY	120,027	14,461,403	0.008300	546,360	4,535	60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	3,043	148,801	0.020450	19,684	403	63.00
65.00	06500	RESPIRATORY THERAPY	128,884	3,147,459	0.040949	140,477	5,752	65.00
66.00	06600	PHYSICAL THERAPY	77,596	2,828,718	0.027432	52,197	1,432	66.00
66.01	06601	PHYSICAL THERAPY- WHEATFIELD	272,023	1,864,358	0.145907	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	16,380	606,757	0.026996	48,697	1,315	67.00
67.01	06701	OCCUPATIONAL THERAPY- WHEATFIELD	57,145	248,507	0.229953	0	0	67.01
68.00	06800	SPEECH PATHOLOGY	13,254	270,870	0.048931	6,383	312	68.00
68.01	06801	SPEECH PATHOLOGY- WHEATFIELD	39,097	539,320	0.072493	0	0	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	98,180	4,755,760	0.020644	104,497	2,157	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	20,685	1,740,822	0.011882	22,776	271	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	93,813	31,663,973	0.002963	477,774	1,416	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	9,966	163,280	0.061036	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	77,884	277,985	0.280173	0	0	88.01
90.00	09000	CLINIC	398,630	4,796,478	0.083109	211	18	90.00
90.01	09001	WOUND CARE	28,383	216,545	0.131072	0	0	90.01
91.00	09100	EMERGENCY	295,977	8,520,474	0.034737	89,606	3,113	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	101,566	2,134,410	0.047585	3,196	152	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	2,334,542	97,876,881		1,704,557	26,168	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1324 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part IV | Date/Time Prepared: 5/29/2023 3:36 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
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
66.01	06601	PHYSICAL THERAPY- WHEATFIELD	0	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
67.01	06701	OCCUPATIONAL THERAPY- WHEATFIELD	0	0	0	0	0	67.01
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
68.01	06801	SPEECH PATHOLOGY- WHEATFIELD	0	0	0	0	0	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CARE	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1324 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part IV Date/Time Prepared: 5/29/2023 3:36 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	2,942,566	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	16,548,395	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	14,461,403	0.000000	60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	0	0	0	148,801	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	3,147,459	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,828,718	0.000000	66.00
66.01	06601	PHYSICAL THERAPY- WHEATFIELD	0	0	0	1,864,358	0.000000	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	606,757	0.000000	67.00
67.01	06701	OCCUPATIONAL THERAPY- WHEATFIELD	0	0	0	248,507	0.000000	67.01
68.00	06800	SPEECH PATHOLOGY	0	0	0	270,870	0.000000	68.00
68.01	06801	SPEECH PATHOLOGY- WHEATFIELD	0	0	0	539,320	0.000000	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	4,755,760	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,740,822	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	31,663,973	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	163,280	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	277,985	0.000000	88.01
90.00	09000	CLINIC	0	0	0	4,796,478	0.000000	90.00
90.01	09001	WOUND CARE	0	0	0	216,545	0.000000	90.01
91.00	09100	EMERGENCY	0	0	0	8,520,474	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	2,134,410	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	97,876,881		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1324 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part IV | Date/Time Prepared: 5/29/2023 3:36 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	35,357	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	157,342	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	546,360	0	0	0	60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	0.000000	19,684	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.000000	140,477	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	52,197	0	0	0	66.00
66.01	06601	PHYSICAL THERAPY- WHEATFIELD	0.000000	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.000000	48,697	0	0	0	67.00
67.01	06701	OCCUPATIONAL THERAPY- WHEATFIELD	0.000000	0	0	0	0	67.01
68.00	06800	SPEECH PATHOLOGY	0.000000	6,383	0	0	0	68.00
68.01	06801	SPEECH PATHOLOGY- WHEATFIELD	0.000000	0	0	0	0	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	104,497	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	22,776	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	477,774	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000	0	0	0	0	88.01
90.00	09000	CLINIC	0.000000	211	0	0	0	90.00
90.01	09001	WOUND CARE	0.000000	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.000000	89,606	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	3,196	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		1,704,557	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1324 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part V Date/Time Prepared: 5/29/2023 3:36 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	0.708429	0	1,012,234	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.180424	0	4,470,681	0	0	54.00
60.00	06000	LABORATORY	0.269572	0	2,320,080	0	0	60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	0.129401	0	57,411	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.487116	0	1,084,713	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.379350	0	639,134	0	0	66.00
66.01	06601	PHYSICAL THERAPY- WHEATFIELD	0.637997	0	894,392	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.459734	0	34,063	0	0	67.00
67.01	06701	OCCUPATIONAL THERAPY- WHEATFIELD	1.151461	0	54,308	0	0	67.01
68.00	06800	SPEECH PATHOLOGY	0.752472	0	11,812	0	0	68.00
68.01	06801	SPEECH PATHOLOGY- WHEATFIELD	0.641804	0	25,552	0	0	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.261626	0	1,595,749	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.150885	0	689,294	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.159310	0	13,777,578	185	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC						88.00
88.01	08801	RURAL HEALTH CLINIC II						88.01
90.00	09000	CLINIC	0.579545	0	1,642,777	0	0	90.00
90.01	09001	WOUND CARE	0.479988	0	55,624	0	0	90.01
91.00	09100	EMERGENCY	0.579742	0	1,985,484	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.554813	0	742,306	6,302	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000		0			95.00
200.00		Subtotal (see instructions)		0	31,093,192	6,487	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	31,093,192	6,487	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1324 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part V Date/Time Prepared: 5/29/2023 3:36 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	717,096	0		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	806,618	0		54.00
60.00	06000	LABORATORY	625,429	0		60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	7,429	0		63.00
65.00	06500	RESPIRATORY THERAPY	528,381	0		65.00
66.00	06600	PHYSICAL THERAPY	242,455	0		66.00
66.01	06601	PHYSICAL THERAPY- WHEATFIELD	570,619	0		66.01
67.00	06700	OCCUPATIONAL THERAPY	15,660	0		67.00
67.01	06701	OCCUPATIONAL THERAPY- WHEATFIELD	62,534	0		67.01
68.00	06800	SPEECH PATHOLOGY	8,888	0		68.00
68.01	06801	SPEECH PATHOLOGY- WHEATFIELD	16,399	0		68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	417,489	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	104,004	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,194,906	29		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC				88.00
88.01	08801	RURAL HEALTH CLINIC II				88.01
90.00	09000	CLINIC	952,063	0		90.00
90.01	09001	WOUND CARE	26,699	0		90.01
91.00	09100	EMERGENCY	1,151,068	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	411,841	3,496		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	8,859,578	3,525		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	8,859,578	3,525		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1324 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-1 | Date/Time Prepared: 5/29/2023 3:36 pm

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,831	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,160	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,486	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	366	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	305	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	632	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)	366	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	250.44	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	250.44	20.00
21.00	Total general inpatient routine service cost (see instructions)	4,514,488	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)	76,384	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	719,435	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,795,053	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	3,795,053	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,756.97	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,110,405	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	1,110,405	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1324 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-1 | Date/Time Prepared: 5/29/2023 3:36 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT	0	0	0.00	0	0	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)	479,420	48.00
48.01	Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)	0	48.01
49.00	Total Program inpatient costs (sum of lines 41 through 48.01)(see instructions)	1,589,825	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
55.01	Permanent adjustment amount per discharge	0.00	55.01
55.02	Adjustment amount per discharge (contractor use only)	0.00	55.02
56.00	Target amount (line 54 x sum of lines 55, 55.01, and 55.02)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)	0.00	59.00
60.00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)	0.00	60.00
61.00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	643,051	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	643,051	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)	674	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,756.97	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,184,198	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1324 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-1 | Date/Time Prepared: 5/29/2023 3:36 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	387,198	4,514,488	0.085768	1,184,198	101,566	90.00
91.00	Nursing Program cost	0	4,514,488	0.000000	1,184,198	0	91.00
92.00	Allied health cost	0	4,514,488	0.000000	1,184,198	0	92.00
93.00	All other Medical Education	0	4,514,488	0.000000	1,184,198	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1324 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-1 | Date/Time Prepared: 5/29/2023 3:36 pm

Title XIX | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,831	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,160	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,486	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	366	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	305	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	12	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	250.40	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	250.40	20.00
21.00	Total general inpatient routine service cost (see instructions)	4,514,488	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)	76,372	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	719,423	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,795,065	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	3,795,065	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,756.97	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	21,084	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)	21,084	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1324 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-1 | Date/Time Prepared: 5/29/2023 3:36 pm

Title XIX | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT	0	0	0.00	0	0	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)	20,064	48.00
48.01	Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)	0	48.01
49.00	Total Program inpatient costs (sum of lines 41 through 48.01)(see instructions)	41,148	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
55.01	Permanent adjustment amount per discharge	0.00	55.01
55.02	Adjustment amount per discharge (contractor use only)	0.00	55.02
56.00	Target amount (line 54 x sum of lines 55, 55.01, and 55.02)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)	0.00	59.00
60.00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)	0.00	60.00
61.00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	674	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,756.97	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,184,198	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1324 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-1 | Date/Time Prepared: 5/29/2023 3:36 pm

Title XIX | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	387,198	4,514,488	0.085768	1,184,198	101,566	90.00
91.00	Nursing Program cost	0	4,514,488	0.000000	1,184,198	0	91.00
92.00	Allied health cost	0	4,514,488	0.000000	1,184,198	0	92.00
93.00	All other Medical Education	0	4,514,488	0.000000	1,184,198	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1324 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-3 | Date/Time Prepared: 5/29/2023 3:36 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		900,952		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
32.00	03200	CORONARY CARE UNIT		0		32.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.708429	35,357	25,048	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.180424	157,342	28,388	54.00
60.00	06000	LABORATORY	0.269572	546,360	147,283	60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	0.129401	19,684	2,547	63.00
65.00	06500	RESPIRATORY THERAPY	0.487116	140,477	68,429	65.00
66.00	06600	PHYSICAL THERAPY	0.379350	52,197	19,801	66.00
66.01	06601	PHYSICAL THERAPY- WHEATFIELD	0.637997	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.459734	48,697	22,388	67.00
67.01	06701	OCCUPATIONAL THERAPY- WHEATFIELD	1.151461	0	0	67.01
68.00	06800	SPEECH PATHOLOGY	0.752472	6,383	4,803	68.00
68.01	06801	SPEECH PATHOLOGY- WHEATFIELD	0.641804	0	0	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.261626	104,497	27,339	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.150885	22,776	3,437	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.159310	477,774	76,114	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0	88.01
90.00	09000	CLINIC	0.579545	211	122	90.00
90.01	09001	WOUND CARE	0.479988	0	0	90.01
91.00	09100	EMERGENCY	0.579742	89,606	51,948	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.554813	3,196	1,773	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,704,557	479,420	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		1,704,557		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-1324 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-3

Component CCN: 15-Z324 | Date/Time Prepared: 5/29/2023 3:36 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
32.00	03200	CORONARY CARE UNIT				32.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.708429	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.180424	7,388	1,333	54.00
60.00	06000	LABORATORY	0.269572	53,087	14,311	60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	0.129401	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.487116	42,267	20,589	65.00
66.00	06600	PHYSICAL THERAPY	0.379350	73,404	27,846	66.00
66.01	06601	PHYSICAL THERAPY- WHEATFIELD	0.637997	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.459734	73,572	33,824	67.00
67.01	06701	OCCUPATIONAL THERAPY- WHEATFIELD	1.151461	0	0	67.01
68.00	06800	SPEECH PATHOLOGY	0.752472	4,282	3,222	68.00
68.01	06801	SPEECH PATHOLOGY- WHEATFIELD	0.641804	0	0	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.261626	23,356	6,111	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.150885	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.159310	79,178	12,614	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0	88.01
90.00	09000	CLINIC	0.579545	0	0	90.00
90.01	09001	WOUND CARE	0.479988	0	0	90.01
91.00	09100	EMERGENCY	0.579742	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.554813	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		356,534	119,850	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)		356,534		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1324 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-3 | Date/Time Prepared: 5/29/2023 3:36 pm

Title XIX | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		21,168		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
32.00	03200	CORONARY CARE UNIT		0		32.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.708429	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.180424	10,351	1,868	54.00
60.00	06000	LABORATORY	0.269572	18,634	5,023	60.00
63.00	06300	BLOOD STORING PROCESSING & TRANS.	0.129401	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.487116	11,970	5,831	65.00
66.00	06600	PHYSICAL THERAPY	0.379350	402	152	66.00
66.01	06601	PHYSICAL THERAPY- WHEATFIELD	0.637997	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.459734	527	242	67.00
67.01	06701	OCCUPATIONAL THERAPY- WHEATFIELD	1.151461	0	0	67.01
68.00	06800	SPEECH PATHOLOGY	0.752472	252	190	68.00
68.01	06801	SPEECH PATHOLOGY- WHEATFIELD	0.641804	0	0	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.261626	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.150885	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.159310	15,752	2,509	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	2.687231	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	2.277252	0	0	88.01
90.00	09000	CLINIC	0.579545	0	0	90.00
90.01	09001	WOUND CARE	0.479988	0	0	90.01
91.00	09100	EMERGENCY	0.579742	7,329	4,249	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.554813	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		65,217	20,064	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)		65,217		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1324	Period: From 01/01/2022 To 12/31/2022	Worksheet E Part B Date/Time Prepared: 5/29/2023 3:36 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	8,863,103	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	OPPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	8,863,103	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	8,951,734	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)	86,029	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	5,709,480	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	3,156,225	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	3,156,225	30.00
31.00	Primary payer payments	6,448	31.00
32.00	Subtotal (line 30 minus line 31)	3,149,777	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)	530,507	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	344,830	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	482,306	36.00
37.00	Subtotal (see instructions)	3,494,607	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.75	N95 respirator payment adjustment amount (see instructions)	0	39.75
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	3,494,607	40.00
40.01	Sequestration adjustment (see instructions)	44,033	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
40.03	Sequestration adjustment-PARHM or CHART pass-throughs		40.03
41.00	Interim payments	4,685,509	41.00
41.01	Interim payments-PARHM or CHART		41.01
42.00	Tentative settlement (for contractors use only)	0	42.00
42.01	Tentative settlement-PARHM or CHART (for contractor use only)		42.01
43.00	Balance due provider/program (see instructions)	-1,234,935	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: 15-1324	Period: From 01/01/2022 To 12/31/2022	Worksheet E Part B Date/Time Prepared: 5/29/2023 3:36 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: 15-1324 | Period: From 01/01/2022 To 12/31/2022 | Worksheet E-1 Part I | Date/Time Prepared: 5/29/2023 3:36 pm

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,499,519		4,685,509	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)		1,499,519		4,685,509	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		170,539		1,234,935	6.02
7.00	Total Medicare program liability (see instructions)		1,328,980		3,450,574	7.00

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-1324 | Component CCN: 15-Z324 | Period: From 01/01/2022 To 12/31/2022 | Worksheet E-1 Part I | Date/Time Prepared: 5/29/2023 3:36 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		607,814		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	12/31/2022	81,300		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)		81,300		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)		689,114		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		68,635		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		757,749		0	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-1324	Period: From 01/01/2022 To 12/31/2022	Worksheet E-1 Part II Date/Time Prepared: 5/29/2023 3:36 pm
	Title XVIII	Hospital	Cost

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

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS | Provider CCN: 15-1324 | Component CCN: 15-Z324 | Period: From 01/01/2022 To 12/31/2022 | Worksheet E-2 | Date/Time Prepared: 5/29/2023 3:36 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)	649,482	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)	121,049	0	3.00
3.01	Nursing and allied health payment-PARHM or CHART (see instructions)			3.01
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	366	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)	770,531	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	770,531	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)	770,531	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	3,112	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (see instructions)	767,419	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)	767,419	0	19.00
19.01	Sequestration adjustment (see instructions)	9,670	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0	0	19.02
19.03	Sequestration adjustment-PARHM or CHART pass-throughs			19.03
19.25	Sequestration for non-claims based amounts (see instructions)	0	0	19.25
20.00	Interim payments	689,114	0	20.00
20.01	Interim payments-PARHM or CHART			20.01
21.00	Tentative settlement (for contractor use only)	0	0	21.00
21.01	Tentative settlement-PARHM or CHART (for contractor use only)			21.01
22.00	Balance due provider/program (line 19 minus lines 19.01, 19.02, 19.25, 20, and 21)	68,635	0	22.00
22.01	Balance due provider/program-PARHM or CHART (see instructions)			22.01
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	23.00
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
	Cost Reimbursement			
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))			201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))			202.00
203.00	Total (sum of lines 201 and 202)			203.00
204.00	Medicare swing-bed SNF discharges (see instructions)			204.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
205.00	Medicare swing-bed SNF target amount			205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)			206.00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)			208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
	Comparision of PPS versus Cost Reimbursement			
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)			215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1324	Period: From 01/01/2022 To 12/31/2022	Worksheet E-3 Part V Date/Time Prepared: 5/29/2023 3:36 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	1,589,825	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)	0	2.00
3.00	Organ acquisition	0	3.00
3.01	Cellular therapy acquisition cost (see instructions)	0	3.01
4.00	Subtotal (sum of lines 1 through 3.01)	1,589,825	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	1,605,723	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	1,605,723	19.00
20.00	Deductibles (exclude professional component)	262,964	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	1,342,759	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	1,342,759	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	4,893	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	3,180	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	3,112	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	1,345,939	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29.98	Recovery of accelerated depreciation.	0	29.98
29.99	Demonstration payment adjustment amount before sequestration	0	29.99
30.00	Subtotal (see instructions)	1,345,939	30.00
30.01	Sequestration adjustment (see instructions)	16,959	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
30.03	Sequestration adjustment-PARHM or CHART		30.03
31.00	Interim payments	1,499,519	31.00
31.01	Interim payments-PARHM or CHART		31.01
32.00	Tentative settlement (for contractor use only)	0	32.00
32.01	Tentative settlement-PARHM or CHART (for contractor use only)		32.01
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)	-170,539	33.00
33.01	Balance due provider/program-PARHM or CHART (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01)		33.01
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-1324 | Period: From 01/01/2022 To 12/31/2022 | Worksheet E-3 Part VII Date/Time Prepared: 5/29/2023 3:36 pm

Title XIX | Hospital | Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	41,148		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant programs only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	41,148	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)	41,148	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	21,168		8.00
9.00	Ancillary service charges	65,217	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)	86,385	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)	86,385	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	45,237	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)	41,148	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	41,148	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)	41,148	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	41,148	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	41,148	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)	41,148	0	40.00
41.00	Interim payments	53,319	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	-12,171	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: 15-1324 | Period: From 01/01/2022 To 12/31/2022 | Worksheet G | Date/Time Prepared: 5/29/2023 3:36 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	111,019	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	4,766,091	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	813,608	0	0	0	7.00
8.00	Prepaid expenses	68,638	0	0	0	8.00
9.00	Other current assets	95,009	0	0	0	9.00
10.00	Due from other funds	83,413	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	5,937,778	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	675,791	0	0	0	12.00
13.00	Land improvements	509,926	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	19,964,808	0	0	0	15.00
16.00	Accumulated depreciation	-17,679,370	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	12,170,429	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	0	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	15,641,584	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	186,027	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	186,027	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	21,765,389	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	2,327,174	0	0	0	37.00
38.00	Salaries, wages, and fees payable	652,791	0	0	0	38.00
39.00	Payroll taxes payable	411,089	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	5,666,406	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	9,057,460	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	43,849,016	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	43,849,016	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	52,906,476	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	-31,141,087				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)	-31,141,087	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	21,765,389	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-1324 | Period: From 01/01/2022 To 12/31/2022 | Worksheet G-1 | Date/Time Prepared: 5/29/2023 3:36 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		-25,610,506		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-5,530,581				2.00
3.00	Total (sum of line 1 and line 2)		-31,141,087		0		3.00
4.00	OTHER	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		-31,141,087		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)		-31,141,087		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	OTHER		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: 15-1324 | Period: From 01/01/2022 To 12/31/2022 | Worksheet G-2 Parts I & II Date/Time Prepared: 5/29/2023 3:36 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	2,463,248		2,463,248	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	2,463,248		2,463,248	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	0		0	11.00
12.00	CORONARY CARE UNIT	0		0	12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	2,463,248		2,463,248	17.00
18.00	Ancillary services	7,006,461	69,444,470	76,450,931	18.00
19.00	Outpatient services	0	8,561,574	8,561,574	19.00
20.00	RURAL HEALTH CLINIC	0	3,064,560	3,064,560	20.00
20.01	RURAL HEALTH CLINIC II	0	277,985	277,985	20.01
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		0	0	22.00
23.00	AMBULANCE SERVICES	0	0	0	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	25.00
26.00	HOSPICE	0	0	0	26.00
27.00	NON-REIMBURSABLE	0	10,898,199	10,898,199	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	9,469,709	92,246,788	101,716,497	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		37,726,726		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)		37,726,726		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-1324 | Period: From 01/01/2022 To 12/31/2022 | Worksheet G-3 | Date/Time Prepared: 5/29/2023 3:36 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	101,716,497	1.00
2.00	Less contractual allowances and discounts on patients' accounts	70,257,444	2.00
3.00	Net patient revenues (line 1 minus line 2)	31,459,053	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	37,726,726	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-6,267,673	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	228,393	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	114,147	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	73,503	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	8,700	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	2,937	20.00
21.00	Rental of vending machines	1,935	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER OPERATING REVENUE	56,142	24.00
24.01	NON-OPERATING REVENUE	252,816	24.01
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	738,573	25.00
26.00	Total (line 5 plus line 25)	-5,529,100	26.00
27.00	OTHER EXPENSE	1,481	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	1,481	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-5,530,581	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1324 | Component CCN: 15-3990 | Period: From 01/01/2022 To 12/31/2022 | Worksheet M-1 | Date/Time Prepared: 5/29/2023 3:36 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	17,490	0	17,490	0	17,490	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	127,358	0	127,358	0	127,358	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	33,524	0	33,524	0	33,524	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	25,418	0	25,418	0	25,418	9.00
10.00	Subtotal (sum of lines 1 through 9)	203,790	0	203,790	0	203,790	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	11,228	11,228	-11,228	0	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	11,228	11,228	-11,228	0	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	203,790	11,228	215,018	-11,228	203,790	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	26,428	26,428	0	26,428	29.00
30.00	Administrative Costs	33,201	2,725	35,926	0	35,926	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	33,201	29,153	62,354	0	62,354	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	236,991	40,381	277,372	-11,228	266,144	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1324 | Component CCN: 15-3990 | Period: From 01/01/2022 To 12/31/2022 | Worksheet M-1 | Date/Time Prepared: 5/29/2023 3:36 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	-7,607	9,883		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	127,358		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	33,524		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	25,418		9.00
10.00	Subtotal (sum of lines 1 through 9)	-7,607	196,183		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	0		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	0		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-7,607	196,183		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	26,428		29.00
30.00	Administrative Costs	-7,113	28,813		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-7,113	55,241		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-14,720	251,424		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1324 | Component CCN: 15-8502 | Period: From 01/01/2022 To 12/31/2022 | Worksheet M-1 | Date/Time Prepared: 5/29/2023 3:36 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	44,288	0	44,288	0	44,288	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	114,629	0	114,629	0	114,629	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	51,148	0	51,148	0	51,148	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	33,835	0	33,835	0	33,835	9.00
10.00	Subtotal (sum of lines 1 through 9)	243,900	0	243,900	0	243,900	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	15,609	15,609	-15,609	0	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	15,609	15,609	-15,609	0	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	243,900	15,609	259,509	-15,609	243,900	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	2,731	2,731	0	2,731	29.00
30.00	Administrative Costs	32,910	12,588	45,498	0	45,498	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	32,910	15,319	48,229	0	48,229	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	276,810	30,928	307,738	-15,609	292,129	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1324 | Component CCN: 15-8502 | Period: From 01/01/2022 To 12/31/2022 | Worksheet M-1 | Date/Time Prepared: 5/29/2023 3:36 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	-35,639	8,649		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	114,629		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	51,148		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	33,835		9.00
10.00	Subtotal (sum of lines 1 through 9)	-35,639	208,261		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	0		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	0		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-35,639	208,261		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	2,731		29.00
30.00	Administrative Costs	-407	45,091		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-407	47,822		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-36,046	256,083		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-1324 | Component CCN: 15-3990 | Period: From 01/01/2022 To 12/31/2022 | Worksheet M-2 | Date/Time Prepared: 5/29/2023 3:36 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	0.00	0	1	0		1.00
2.00	Physician Assistant	0.00	0	1	0		2.00
3.00	Nurse Practitioner	0.93	924	1	1		3.00
4.00	Subtotal (sum of lines 1 through 3)	0.93	924		1	924	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	0.93	924			924	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)					196,183	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)					196,183	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)					55,241	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					187,347	15.00
16.00	Total overhead (sum of lines 14 and 15)					242,588	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					242,588	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					242,588	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					438,771	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-1324 | Component CCN: 15-8502 | Period: From 01/01/2022 To 12/31/2022 | Worksheet M-2 | Date/Time Prepared: 5/29/2023 3:36 pm

RHC II | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.00	0	1	0		1.00
2.00	Physician Assistant	0.00	0	1	0		2.00
3.00	Nurse Practitioner	0.90	1,710	1	1		3.00
4.00	Subtotal (sum of lines 1 through 3)	0.90	1,710		1	1,710	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	0.90	1,710			1,710	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)					208,261	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)					208,261	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)					47,822	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					376,959	15.00
16.00	Total overhead (sum of lines 14 and 15)					424,781	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					424,781	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					424,781	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					633,042	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 15-1324 Component CCN: 15-3990	Period: From 01/01/2022 To 12/31/2022	Worksheet M-3 Date/Time Prepared: 5/29/2023 3:36 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)		438,771	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)		2,019	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)		436,752	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		924	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)		924	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		472.68	7.00

		Calculation of Limit (1)		
		Rate Period N/A	Rate Period 1 (01/01/2022 through 12/31/2022)	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	0.00	289.04	8.00
9.00	Rate for Program covered visits (see instructions)	0.00	289.04	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	238	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	68,792	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	68,792	16.00
16.01	Total program charges (see instructions)(from contractor's records)		33,207	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		8,704	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		18,031	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.)		36,921	16.04
16.05	Total program cost (see instructions)	0	54,952	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		4,610	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		3,979	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		54,952	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		999	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		55,951	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)		55,951	26.00
26.01	Sequestration adjustment (see instructions)		705	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		53,931	27.00
28.00	Tentative settlement (for contractor use only)		0	28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)		1,315	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: 15-1324 Component CCN: 15-8502	Period: From 01/01/2022 To 12/31/2022	Worksheet M-3 Date/Time Prepared: 5/29/2023 3:36 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)			633,042	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			25,038	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			608,004	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			1,710	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			0	5.00
6.00	Total adjusted visits (line 4 plus line 5)			1,710	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			355.56	7.00
		Calculation of Limit (1)			
		Rate Period N/A	Rate Period 1 (01/01/2022 through 12/31/2022)		
		1.00	2.00		
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	0.00	218.69		8.00
9.00	Rate for Program covered visits (see instructions)	0.00	218.69		9.00
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	0	498		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	108,908		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	108,908		16.00
16.01	Total program charges (see instructions)(from contractor's records)		65,134		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		9,014		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		15,072		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.)		66,033		16.04
16.05	Total program cost (see instructions)	0	81,105		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		11,295		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		8,965		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		81,105		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		14,725		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		95,830		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)		95,830		26.00
26.01	Sequestration adjustment (see instructions)		1,208		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		80,165		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)		14,457		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: 15-1324 | Component CCN: 15-3990 | Period: From 01/01/2022 To 12/31/2022 | Worksheet M-4 | Date/Time Prepared: 5/29/2023 3:36 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)	196,183	196,183	196,183	196,183	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000071	0.000534	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	14	105	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	34	750	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	48	855	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	196,183	196,183	196,183	196,183	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	242,588	242,588	242,588	242,588	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.000245	0.004358	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	59	1,057	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	107	1,912	0	0	10.00
11.00	Total number of injections/infusions (from your records)	2	15	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	53.50	127.47	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	2	7	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)	107	892	0	0	14.00

			COST OF INJECTIONS / INFUSIONS AND ADMINISTRATION	
		1.00	2.00	
15.00	Total cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. M-3, line 2)		2,019	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)		999	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 15-1324 | Component CCN: 15-8502 | Period: From 01/01/2022 To 12/31/2022 | Worksheet M-4 | Date/Time Prepared: 5/29/2023 3:36 pm

Title XVIII | RHC II | Cost

		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	208,261	208,261	208,261	208,261	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000834	0.004021	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	174	837	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	476	6,750	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	650	7,587	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	208,261	208,261	208,261	208,261	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	424,781	424,781	424,781	424,781	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.003121	0.036430	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	1,326	15,475	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	1,976	23,062	0	0	10.00
11.00	Total number of injections/infusions (from your records)	28	135	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	70.57	170.83	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	15	80	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)	1,059	13,666	0	0	14.00

			COST OF INJECTIONS / INFUSIONS AND ADMINISTRATION	
		1.00	2.00	
15.00	Total cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. M-3, line 2)		25,038	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)		14,725	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 15-1324 Component CCN: 15-3990	Period: From 01/01/2022 To 12/31/2022	Worksheet M-5 Date/Time Prepared: 5/29/2023 3:36 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		53,931	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)		53,931	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		1,315	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		55,246	7.00

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

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

Provider CCN: 15-1324 | Component CCN: 15-8502 | Period: From 01/01/2022 To 12/31/2022 | Worksheet M-5 | Date/Time Prepared: 5/29/2023 3:36 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		80,165	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)		80,165	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		14,457	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		94,622	7.00

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