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: 15-1329	Period: From 01/01/2022 To 12/31/2022	Worksheet S Parts I-III Date/Time Prepared: 5/26/2023 12:48 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 5/26/2023 Time: 12:48 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 MARGARET MARY COMMUNITY HOSPITAL (15-1329) 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	Craig Gilliland		Y	I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name	Craig Gilliland			2
3	Signatory Title	CFO			3
4	Date	(Dated when report is electronica			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	197,262	-1,890,137	0	-6,107	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	23,577	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		-18,043		0	10.00
10.01	MEDICAL ARTS CENTER II	0		9,880		0	10.01
200.00	TOTAL	0	220,839	-1,898,300	0	-6,107	200.00

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

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The number for this information collection is OMB 0938-0050 and the number for the Supplement to Form CMS 2552-10, Worksheet N95, is OMB 0938-1425. The time required to complete and review the information collection is estimated 675 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.
Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1329 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-2 Part I Date/Time Prepared: 5/26/2023 12:48 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 321 MITCHELL	PO Box:			1.00
2.00	City: BATESVILLE	State: IN	Zip Code: 47006-	County: RIPLEY	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	MARGARET MARY COMMUNITY HOSPITAL	151329	99915	1	01/07/1966	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	MARGARET MARY COMMUNITY HOSPITAL	15Z329	99915		09/10/2020	N	O	O	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	MARGARET MARY COMMUNITY HOSPITAL	151551	99915		12/31/2003				14.00
15.00	Hospital-Based Health Clinic - RHC	MARGARET MARY COMMUNITY HOSPITAL	158511	99915		09/03/2013	N	O	N	15.00
15.01	Hospital-Based Health Clinic - RHC II	MEDICAL ARTS CENTER	158567	99915		06/04/2022	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)	2		21.00

		1.00	2.00	3.00	
	Inpatient PPS Information				
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N			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: 15-1329 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-2 Part I | Date/Time Prepared: 5/26/2023 12:48 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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1329 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-2 Part I | Date/Time Prepared: 5/26/2023 12:48 pm

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

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

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)				0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1329 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-2 Part I Date/Time Prepared: 5/26/2023 12:48 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: 15-1329 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-2 Part I | Date/Time Prepared: 5/26/2023 12:48 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: 15-1329 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-2 Part I | Date/Time Prepared: 5/26/2023 12:48 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.	N			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

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		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	458,931	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)	N		140.00

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

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

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

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					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: 15-1329 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-2 Part II | Date/Time Prepared: 5/26/2023 12:48 pm

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

		Y/N	Date	
		1.00	2.00	
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00

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

Financial Data and Reports

		Y/N	Type	Date	
		1.00	2.00	3.00	
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

Approved Educational Activities

		Y/N	Legal Oper.	
		1.00	2.00	
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

Bad Debts

		Y/N	
		1.00	
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

PS&R Data

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	01/04/2023	Y	01/04/2023	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

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

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

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?	N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	N		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.	KYLE	SMITH	41.00
42.00	Enter the employer/company name of the cost report preparer.	BLUE & CO., LLC		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-713-7957	KCSMITH@BLUEANDCO.COM	43.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1329 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-3 Part I Date/Time Prepared: 5/26/2023 12:48 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	18	6,570	92,760.00	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)		18	6,570	92,760.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	7	2,555	6,960.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		25	9,125	99,720.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	116.00	0	0			24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	88.00				0	26.00
26.01	MEDICAL ARTS CENTER	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

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	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)	1,369	11	3,731			1.00
2.00	HMO and other (see instructions)	1,047	279				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	176	0	176			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	112			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,545	11	4,019			7.00
8.00	INTENSIVE CARE UNIT	99	0	290			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		0	768			13.00
14.00	Total (see instructions)	1,644	11	5,077	0.00	579.56	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0	0	0	0.00	0.00	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0	0	0	0.00	11.04	24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	1,629	3,443	11,439	0.00	19.10	26.00
26.01	MEDICAL ARTS CENTER	1,239	220	9,689	0.00	27.40	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	637.10	27.00
28.00	Observation Bed Days		600	1,770			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: 15-1329 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-3 Part I | Date/Time Prepared: 5/26/2023 12:48 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	354	7	1,263	1.00
2.00	HMO and other (see instructions)			198	105		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	354	7	1,263	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0.00					24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0.00					26.00
26.01	MEDICAL ARTS CENTER	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: 15-1329 | Component CCN: 15-8511 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-8 | Date/Time Prepared: 5/26/2023 12:48 pm

RHC I | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			112 N. BUCKEYE ST.		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	OSGOOD		IN	47037	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	CLINIC			08:00	16:30	08:00	11.00

				1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?			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	08:00	16:30	08:00	16:30	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-1329 | Component CCN: 15-8511 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-8 | Date/Time Prepared: 5/26/2023 12:48 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	07:00	06:00	08:00	12:00		11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-1329 | Component CCN: 15-8567 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-8 | Date/Time Prepared: 5/26/2023 12:48 pm

RHC II | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			188 STATE ROUTE 129		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	BATESVILLE		IN	47006	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	CLINIC			08:00	16:30	08:00	11.00

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

		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC	16:30	08:00	16:30	08:00	16:30	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 15-1329
Component CCN: 15-8567

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

Worksheet S-8
Date/Time Prepared:
5/26/2023 12:48 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	07:00	06:00	08:00	12:00		11.00

HOSPITAL-BASED HOSPICE IDENTIFICATION DATA

Provider CCN: 15-1329
Hospice CCN: 15-1551

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

Worksheet S-9
PARTS I THROUGH IV
Date/Time Prepared:
5/26/2023 12:48 pm

Hospice I

		Unduplicated Days						
		Title XVIII	Title XIX	Title XVIII Skilled Nursing Facility	Title XIX Nursing Facility	All Other	Total (sum of cols. 1, 2 & 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART I - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING BEFORE OCTOBER 1, 2015							
1.00	Hospice Continuous Home Care							1.00
2.00	Hospice Routine Home Care							2.00
3.00	Hospice Inpatient Respite Care							3.00
4.00	Hospice General Inpatient Care							4.00
5.00	Total Hospice Days							5.00
	Part II - CENSUS DATA FOR COST REPORTING PERIODS BEGINNING BEFORE OCTOBER 1, 2015							
6.00	Number of patients receiving hospice care							6.00
7.00	Total number of unduplicated Continuous Care hours billable to Medicare							7.00
8.00	Average Length of Stay (line 5 / line 6)							8.00
9.00	Unduplicated census count							9.00

NOTE: Parts I and II, columns 1 and 2 also include the days reported in columns 3 and 4.

		Title XVIII	Title XIX	Other	Total (sum of cols. 1 through 3)	
		1.00	2.00	3.00	4.00	
	PART III - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015					
10.00	Hospice Continuous Home Care	0	0	0	0	10.00
11.00	Hospice Routine Home Care	9,567	10	636	10,213	11.00
12.00	Hospice Inpatient Respite Care	10	0	0	10	12.00
13.00	Hospice General Inpatient Care	0	0	0	0	13.00
14.00	Total Hospice Days	9,577	10	636	10,223	14.00
	PART IV - CONTRACTED STATISTICAL DATA FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015					
15.00	Hospice Inpatient Respite Care	0	0	0	0	15.00
16.00	Hospice General Inpatient Care	0	0	0	0	16.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-1329 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-10 | Date/Time Prepared: 5/26/2023 12:48 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)	0.308859	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	5,888,179	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	N	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	29,667,207	6.00
7.00	Medicaid cost (line 1 times line 6)	9,162,984	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	3,274,805	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	3,274,805	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)	251,470	846,664	1,098,134	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	77,669	846,664	924,333	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)	77,669	846,664	924,333	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)	6,782,454	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	494,839	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	761,290	27.01
28.00	Non-Medicare bad debt expense (see instructions)	6,021,164	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	2,126,142	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	3,050,475	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	6,325,280	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1329 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A | Date/Time Prepared: 5/26/2023 12:48 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		2,797,776	2,797,776	-34,136	2,763,640	1.00
1.01	00101	NEW CAP REL COSTS-OFFSITE BLDG		836,691	836,691	34,136	870,827	1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		4,720,255	4,720,255	-380,170	4,340,085	2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT		0	0	380,170	380,170	2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	227,974	18,272,650	18,500,624	0	18,500,624	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	6,828,772	13,390,034	20,218,806	368,727	20,587,533	5.00
7.00	00700	OPERATION OF PLANT	0	1,581,496	1,581,496	-78	1,581,418	7.00
7.01	00701	OPERATION OF PLANT -OFFSITE	0	435,293	435,293	0	435,293	7.01
7.02	00702	OPERATION OF PLANT - HOSPITAL & OFFS	590,111	21,966	612,077	0	612,077	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	146,976	82,340	229,316	-15,999	213,317	8.00
9.00	00900	HOUSEKEEPING	893,170	407,094	1,300,264	-2,045	1,298,219	9.00
10.00	01000	DIETARY	569,524	589,860	1,159,384	-1,021,315	138,069	10.00
11.00	01100	CAFETERIA	0	0	0	978,316	978,316	11.00
13.00	01300	NURSING ADMINISTRATION	1,517,347	2,029,117	3,546,464	0	3,546,464	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	655,473	3,545,934	4,201,407	-14,351	4,187,056	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	854,509	33,584	888,093	0	888,093	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,047,990	1,575,619	3,623,609	483,489	4,107,098	30.00
31.00	03100	INTENSIVE CARE UNIT	355,521	28,231	383,752	-19,983	363,769	31.00
43.00	04300	NURSERY	0	3,544	3,544	713,102	716,646	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,835,396	4,020,176	5,855,572	-3,420,275	2,435,297	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,474,503	243,947	1,718,450	-1,589,634	128,816	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,652,140	10,155,137	13,807,277	-391,581	13,415,696	54.00
60.00	06000	LABORATORY	1,796,759	2,599,871	4,396,630	-72,576	4,324,054	60.00
65.00	06500	RESPIRATORY THERAPY	850,104	150,441	1,000,545	-35,153	965,392	65.00
66.00	06600	PHYSICAL THERAPY	1,050,657	45,672	1,096,329	-8,766	1,087,563	66.00
67.00	06700	OCCUPATIONAL THERAPY	315,977	11,920	327,897	-9,276	318,621	67.00
68.00	06800	SPEECH PATHOLOGY	157,120	2,104	159,224	-422	158,802	68.00
69.00	06900	ELECTROCARDIOLOGY	642,515	246,506	889,021	-32,522	856,499	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	3,292,214	3,292,214	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	1,920,354	1,920,354	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	1,444,335	195,161	1,639,496	0	1,639,496	88.00
88.01	08801	MEDICAL ARTS CENTER	2,564,356	196,573	2,760,929	-1,150,479	1,610,450	88.01
90.00	09000	CLINIC	2,549,771	1,213,874	3,763,645	-242,922	3,520,723	90.00
90.01	09001	WOUND CLINC	349,136	252,922	602,058	-247,794	354,264	90.01
90.02	09002	BEHAVIORAL HEALTH	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	2,324,194	2,842,167	5,166,361	-258,396	4,907,965	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		0	0	0	0	113.00
116.00	11600	HOSPICE	685,703	334,338	1,020,041	0	1,020,041	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	36,380,033	72,862,293	109,242,326	-777,365	108,464,961	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	10,869,700	2,810,384	13,680,084	1,150,479	14,830,563	192.00
192.01	19201	PEDIATRICS	368,399	33,261	401,660	0	401,660	192.01
192.02	19202	BROOKVILLE	2,655,536	248,959	2,904,495	0	2,904,495	192.02
192.03	19203	RADIOLOGY - OSGOOD	98,717	0	98,717	0	98,717	192.03
192.04	19204	ENT	0	0	0	0	0	192.04
194.00	07950	COMMUNITY RELATIONS	411,612	793,810	1,205,422	-373,114	832,308	194.00
194.01	07951	COMMUNITY BENEFITS	519,369	188,215	707,584	0	707,584	194.01
194.02	07952	OTHER NON-REIMBURSABLE	0	0	0	0	0	194.02
194.03	07953	EMS	17,032	172,033	189,065	0	189,065	194.03
194.04	07954	BATESVILLE TOOL & DIE CLINIC	203,536	21,568	225,104	0	225,104	194.04
194.05	07955	MMHCB RHC	0	0	0	0	0	194.05
194.06	07956	FOUNDATION	177,340	148,047	325,387	0	325,387	194.06
194.07	07957	FQHC	0	0	0	0	0	194.07
200.00		TOTAL (SUM OF LINES 118 through 199)	51,701,274	77,278,570	128,979,844	0	128,979,844	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1329 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A | Date/Time Prepared: 5/26/2023 12:48 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	-578,419	2,185,221		1.00
1.01	00101	NEW CAP REL COSTS-OFFSITE BLDG	0	870,827		1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	-7,460	4,332,625		2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT	0	380,170		2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-152,906	18,347,718		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-5,691,886	14,895,647		5.00
7.00	00700	OPERATION OF PLANT	0	1,581,418		7.00
7.01	00701	OPERATION OF PLANT -OFFSITE	0	435,293		7.01
7.02	00702	OPERATION OF PLANT - HOSPITAL & OFFS	0	612,077		7.02
8.00	00800	LAUNDRY & LINEN SERVICE	0	213,317		8.00
9.00	00900	HOUSEKEEPING	0	1,298,219		9.00
10.00	01000	DIETARY	0	138,069		10.00
11.00	01100	CAFETERIA	-278,288	700,028		11.00
13.00	01300	NURSING ADMINISTRATION	-12,900	3,533,564		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0		14.00
15.00	01500	PHARMACY	0	4,187,056		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-312	887,781		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-1,263,429	2,843,669		30.00
31.00	03100	INTENSIVE CARE UNIT	0	363,769		31.00
43.00	04300	NURSERY	0	716,646		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-113,000	2,322,297		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	128,816		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-1,570,486	11,845,210		54.00
60.00	06000	LABORATORY	0	4,324,054		60.00
65.00	06500	RESPIRATORY THERAPY	0	965,392		65.00
66.00	06600	PHYSICAL THERAPY	-10,764	1,076,799		66.00
67.00	06700	OCCUPATIONAL THERAPY	-1,425	317,196		67.00
68.00	06800	SPEECH PATHOLOGY	0	158,802		68.00
69.00	06900	ELECTROCARDIOLOGY	-63,719	792,780		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,292,214		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	1,920,354		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	1,639,496		88.00
88.01	08801	MEDICAL ARTS CENTER	0	1,610,450		88.01
90.00	09000	CLINIC	-2,107,225	1,413,498		90.00
90.01	09001	WOUND CLINC	-58,971	295,293		90.01
90.02	09002	BEHAVIORAL HEALTH	0	0		90.02
91.00	09100	EMERGENCY	-1,542,281	3,365,684		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	0		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
116.00	11600	HOSPICE	0	1,020,041		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-13,453,471	95,011,490		118.00
		NONREIMBURSABLE COST CENTERS				
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	14,830,563		192.00
192.01	19201	PEDIATRICS	0	401,660		192.01
192.02	19202	BROOKVILLE	0	2,904,495		192.02
192.03	19203	RADIOLOGY - OSGOOD	0	98,717		192.03
192.04	19204	ENT	0	0		192.04
194.00	07950	COMMUNITY RELATIONS	0	832,308		194.00
194.01	07951	COMMUNITY BENEFITS	0	707,584		194.01
194.02	07952	OTHER NON-REIMBURSABLE	0	0		194.02
194.03	07953	EMS	0	189,065		194.03
194.04	07954	BATESVILLE TOOL & DIE CLINIC	0	225,104		194.04
194.05	07955	MMHCB RHC	0	0		194.05
194.06	07956	FOUNDATION	-41,116	284,271		194.06
194.07	07957	FQHC	0	0		194.07
200.00		TOTAL (SUM OF LINES 118 through 199)	-13,494,587	115,485,257		200.00

RECLASSIFICATIONS | Provider CCN: 15-1329 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-6 | Date/Time Prepared: 5/26/2023 12:48 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - CAFETERIA					
1.00	CAFETERIA	11.00	480,578	497,738		1.00
	0		480,578	497,738		
	B - OB RECLASS					
1.00	ADULTS & PEDIATRICS	30.00	680,631	50,443		1.00
2.00	NURSERY	43.00	663,969	49,208		2.00
	0		1,344,600	99,651		
	C - COMMUNITY RELATIONS					
1.00	ADMINISTRATIVE & GENERAL	5.00	144,064	229,050		1.00
	0		144,064	229,050		
	D - IMPLANTABLE SUPPLIES RECLASS					
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	1,920,354		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
	0		0	1,920,354		
	E - OFFSITE BUILDING DEPR RECLASS					
1.00	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT	2.01	0	380,170		1.00
	0		0	380,170		
	F - CENTRAL SUPPLY RECLASS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	3,292,214		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
20.00		0.00	0	0		20.00
21.00		0.00	0	0		21.00
	0		0	3,292,214		
	G - DEPRECIATION RECLASS					
1.00	NEW CAP REL COSTS-OFFSITE BLDG	1.01	0	34,136		1.00
	0		0	34,136		
	H - MAC RHC RECLASS					
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	1,068,567	81,912		1.00
	TOTALS		1,068,567	81,912		
500.00	Grand Total: Increases		3,037,809	6,535,225		500.00

RECLASSIFICATIONS | Provider CCN: 15-1329 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-6 | Date/Time Prepared: 5/26/2023 12:48 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	480,578	497,738	0		1.00
	0		480,578	497,738			
	B - OB RECLASS						
1.00	DELIVERY ROOM & LABOR ROOM	52.00	1,344,600	99,651	0		1.00
2.00		0.00	0	0	0		2.00
	0		1,344,600	99,651			
	C - COMMUNITY RELATIONS						
1.00	COMMUNITY RELATIONS	194.00	144,064	229,050	0		1.00
	0		144,064	229,050			
	D - IMPLANTABLE SUPPLIES RECLASS						
1.00	ADULTS & PEDIATRICS	30.00	0	17,113	0		1.00
2.00	OPERATING ROOM	50.00	0	1,901,753	0		2.00
3.00	CLINIC	90.00	0	1,488	0		3.00
	0		0	1,920,354			
	E - OFFSITE BUILDING DEPR RECLASS						
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	380,170	9		1.00
	0		0	380,170			
	F - CENTRAL SUPPLY RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	4,387	0		1.00
2.00	OPERATION OF PLANT	7.00	0	78	0		2.00
3.00	LAUNDRY & LINEN SERVICE	8.00	0	15,999	0		3.00
4.00	HOUSEKEEPING	9.00	0	2,045	0		4.00
5.00	DIETARY	10.00	0	42,999	0		5.00
6.00	PHARMACY	15.00	0	14,351	0		6.00
7.00	ADULTS & PEDIATRICS	30.00	0	230,472	0		7.00
8.00	INTENSIVE CARE UNIT	31.00	0	19,983	0		8.00
9.00	NURSERY	43.00	0	75	0		9.00
10.00	OPERATING ROOM	50.00	0	1,518,522	0		10.00
11.00	DELIVERY ROOM & LABOR ROOM	52.00	0	145,383	0		11.00
12.00	RADIOLOGY-DIAGNOSTIC	54.00	0	391,581	0		12.00
13.00	LABORATORY	60.00	0	72,576	0		13.00
14.00	RESPIRATORY THERAPY	65.00	0	35,153	0		14.00
15.00	PHYSICAL THERAPY	66.00	0	8,766	0		15.00
16.00	OCCUPATIONAL THERAPY	67.00	0	9,276	0		16.00
17.00	SPEECH PATHOLOGY	68.00	0	422	0		17.00
18.00	ELECTROCARDIOLOGY	69.00	0	32,522	0		18.00
19.00	CLINIC	90.00	0	241,434	0		19.00
20.00	WOUND CLINC	90.01	0	247,794	0		20.00
21.00	EMERGENCY	91.00	0	258,396	0		21.00
	0		0	3,292,214			
	G - DEPRECIATION RECLASS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	34,136	9		1.00
	0		0	34,136			
	H - MAC RHC RECLASS						
1.00	MEDICAL ARTS CENTER	88.01	1,068,567	81,912	0		1.00
	TOTALS		1,068,567	81,912			
500.00	Grand Total: Decreases		3,037,809	6,535,225			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1329 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-7 Part I | Date/Time Prepared: 5/26/2023 12:48 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	5,798,684	0	0	0	0	1.00
2.00	Land Improvements	278,583	0	0	0	0	2.00
3.00	Buildings and Fixtures	81,184,011	94,181	0	94,181	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	5,263,075	2,352,825	0	2,352,825	0	5.00
6.00	Movable Equipment	65,509,707	2,897,446	0	2,897,446	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	158,034,060	5,344,452	0	5,344,452	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	158,034,060	5,344,452	0	5,344,452	0	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	5,798,684	0	1.00
2.00	Land Improvements	278,583	0	2.00
3.00	Buildings and Fixtures	81,278,192	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	7,615,900	0	5.00
6.00	Movable Equipment	68,407,153	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	163,378,512	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	163,378,512	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1329 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-7 Part II | Date/Time Prepared: 5/26/2023 12:48 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	2,028,381	0	769,395	0	0	1.00
1.01	NEW CAP REL COSTS-OFFSITE BLDG	836,691	0	0	0	0	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	4,720,255	0	0	0	0	2.00
2.01	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT	0	0	0	0	0	2.01
3.00	Total (sum of lines 1-2)	7,585,327	0	769,395	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL		
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	2,797,776	1.00
1.01	NEW CAP REL COSTS-OFFSITE BLDG	0	836,691	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	4,720,255	2.00
2.01	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT	0	0	2.01
3.00	Total (sum of lines 1-2)	0	8,354,722	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1329 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-7 Part III | Date/Time Prepared: 5/26/2023 12:48 pm

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	64,233,654	0	64,233,654	0.395145	0	1.00
1.01	NEW CAP REL COSTS-OFFSITE BLDG	20,379,218	0	20,379,218	0.125366	0	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	77,944,289	0	77,944,289	0.479489	0	2.00
2.01	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT	0	0	0	0.000000	0	2.01
3.00	Total (sum of lines 1-2)	162,557,161	0	162,557,161	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	1,994,245	0	1.00
1.01	NEW CAP REL COSTS-OFFSITE BLDG	0	0	0	870,827	0	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	4,332,625	0	2.00
2.01	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT	0	0	0	380,170	0	2.01
3.00	Total (sum of lines 1-2)	0	0	0	7,577,867	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	190,976	0	0	0	2,185,221	1.00
1.01	NEW CAP REL COSTS-OFFSITE BLDG	0	0	0	0	870,827	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	4,332,625	2.00
2.01	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT	0	0	0	0	380,170	2.01
3.00	Total (sum of lines 1-2)	190,976	0	0	0	7,768,843	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1329 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-8 | Date/Time Prepared: 5/26/2023 12:48 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
1.01	Investment income - NEW CAP REL COSTS-OFFSITE BLDG (chapter 2)		0	NEW CAP REL COSTS-OFFSITE BLDG	1.01	0	1.01
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
2.01	Investment income - NEW CAP REL COSTS-MVBLE EQUIP OFFSIT (chapter 2)		0	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT	2.01	0	2.01
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-6,686,115			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-277,107	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	-1,181	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 - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
26.01	Depreciation - NEW CAP REL COSTS-OFFSITE BLDG		0	NEW CAP REL COSTS-OFFSITE BLDG	1.01	0	26.01

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1329 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-8 | Date/Time Prepared: 5/26/2023 12:48 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	
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
27.01	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP OFFSIT		0	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT	2.01	0	27.01
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	A	-7,460	NEW CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00	OTHER INCOME	B	-152,906	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.00
35.00	OTHER OPERATING - OTHER OPER. - MISC	B	-6,298	ADMINISTRATIVE & GENERAL	5.00	0	35.00
37.00	OTHER OPERATING - OTHER OPER. - MEDI	B	-312	MEDICAL RECORDS & LIBRARY	16.00	0	37.00
38.00	OTHER OPERATING - OTHER OPER. - PHYS	B	-10,764	PHYSICAL THERAPY	66.00	0	38.00
39.00	OTHER OPERATING - OTHER OPER. - OCCU	B	-1,425	OCCUPATIONAL THERAPY	67.00	0	39.00
40.00	OTHER OPERATING - OTHER OPER. - OUTP	B	-44,404	CLINIC	90.00	0	40.00
43.00	INTEREST OFFSET	A	-578,419	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	43.00
44.00	LOBBYING EXPENSE	A	-7,647	ADMINISTRATIVE & GENERAL	5.00	0	44.00
45.00	MEDICAL STAFF RETENTION COST	A	-71,488	ADMINISTRATIVE & GENERAL	5.00	0	45.00
45.01	HAF	A	-5,528,531	ADMINISTRATIVE & GENERAL	5.00	0	45.01
45.02	TELEPHONE & TV OFFSET	A	-2,052	ADMINISTRATIVE & GENERAL	5.00	0	45.02
45.03	BOUTIQUE OFFSET	A	-1,285	RADIOLOGY-DIAGNOSTIC	54.00	0	45.03
45.04	HOSPITALIST OFFSET	A	-207	ADULTS & PEDIATRICS	30.00	0	45.04
45.05	MEDICAL STAFF PLACEMENT FEE	A	-75,870	ADMINISTRATIVE & GENERAL	5.00	0	45.05
45.07	FOUNDATION GRANT EXPENSE TO HOSPITAL	A	-41,116	FOUNDATION	194.06	0	45.07
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-13,494,587				50.00

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-1329 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-8-2 | Date/Time Prepared: 5/26/2023 12:48 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	71,360	0	71,360	0	0	1.00
2.00	13.00	NURSING ADMINISTRATION	12,900	12,900	0	0	0	2.00
3.00	30.00	ADULTS & PEDIATRICS	1,318,022	1,263,222	54,800	0	0	3.00
4.00	50.00	OPERATING ROOM	168,000	113,000	55,000	0	0	4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	1,627,201	1,569,201	58,000	0	0	5.00
6.00	60.00	LABORATORY	69,930	0	69,930	0	0	6.00
7.00	69.00	ELECTROCARDIOLOGY	103,719	63,719	40,000	0	0	7.00
8.00	90.00	CLINIC	2,097,821	2,062,821	35,000	0	0	8.00
9.00	90.01	WOUND CLINC	58,971	58,971	0	0	0	9.00
10.00	91.00	EMERGENCY	3,134,082	1,542,281	1,591,801	0	0	10.00
200.00			8,662,006	6,686,115	1,975,891		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	13.00	NURSING ADMINISTRATION	0	0	0	0	0	2.00
3.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	3.00
4.00	50.00	OPERATING ROOM	0	0	0	0	0	4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	5.00
6.00	60.00	LABORATORY	0	0	0	0	0	6.00
7.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	7.00
8.00	90.00	CLINIC	0	0	0	0	0	8.00
9.00	90.01	WOUND CLINC	0	0	0	0	0	9.00
10.00	91.00	EMERGENCY	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	13.00	NURSING ADMINISTRATION	0	0	0	12,900		2.00
3.00	30.00	ADULTS & PEDIATRICS	0	0	0	1,263,222		3.00
4.00	50.00	OPERATING ROOM	0	0	0	113,000		4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	1,569,201		5.00
6.00	60.00	LABORATORY	0	0	0	0		6.00
7.00	69.00	ELECTROCARDIOLOGY	0	0	0	63,719		7.00
8.00	90.00	CLINIC	0	0	0	2,062,821		8.00
9.00	90.01	WOUND CLINC	0	0	0	58,971		9.00
10.00	91.00	EMERGENCY	0	0	0	1,542,281		10.00
200.00			0	0	0	6,686,115		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1329 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part I | Date/Time Prepared: 5/26/2023 12:48 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS				
				NEW BLDG & FIXT	NEW OFFSITE BLDG	NEW MVBLE EQUIP	NEW MVBLE EQUIP OFFSIT	
			0	1.00	1.01	2.00	2.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	2,185,221	2,185,221				1.00
1.01	00101	NEW CAP REL COSTS-OFFSITE BLDG	870,827	0	870,827			1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	4,332,625			4,332,625		2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT	380,170			0	380,170	2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	18,347,718	9,349	0	18,535	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	14,895,647	327,102	0	648,543	0	5.00
7.00	00700	OPERATION OF PLANT	1,581,418	396,398	0	785,927	0	7.00
7.01	00701	OPERATION OF PLANT -OFFSITE	435,293	0	0	0	0	7.01
7.02	00702	OPERATION OF PLANT - HOSPITAL & OFFS	612,077	0	0	0	0	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	213,317	24,814	0	49,199	0	8.00
9.00	00900	HOUSEKEEPING	1,298,219	28,308	0	56,126	0	9.00
10.00	01000	DIETARY	138,069	21,293	0	42,218	0	10.00
11.00	01100	CAFETERIA	700,028	60,469	0	119,891	0	11.00
13.00	01300	NURSING ADMINISTRATION	3,533,564	842	0	1,670	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	10,453	0	20,726	0	14.00
15.00	01500	PHARMACY	4,187,056	8,340	0	16,537	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	887,781	38,250	0	75,839	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,843,669	205,239	0	406,927	0	30.00
31.00	03100	INTENSIVE CARE UNIT	363,769	19,180	0	38,029	0	31.00
43.00	04300	NURSERY	716,646	10,177	0	20,178	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,322,297	54,047	0	107,160	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	128,816	17,040	0	33,785	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,845,210	270,292	0	535,907	0	54.00
60.00	06000	LABORATORY	4,324,054	48,054	0	95,277	0	60.00
65.00	06500	RESPIRATORY THERAPY	965,392	36,745	0	72,854	0	65.00
66.00	06600	PHYSICAL THERAPY	1,076,799	76,942	0	152,553	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	317,196	16,142	0	32,006	0	67.00
68.00	06800	SPEECH PATHOLOGY	158,802	14,748	0	29,240	0	68.00
69.00	06900	ELECTROCARDIOLOGY	792,780	33,279	0	65,982	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,292,214	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,920,354	46,080	0	91,362	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	1,639,496	0	50,425	0	22,014	88.00
88.01	08801	MEDICAL ARTS CENTER	1,610,450	0	62,845	0	27,436	88.01
90.00	09000	CLINIC	1,413,498	193,502	0	383,655	0	90.00
90.01	09001	WOUND CLINC	295,293	10,895	0	21,602	0	90.01
90.02	09002	BEHAVIORAL HEALTH	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	3,365,684	123,450	0	244,764	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	1,020,041	2,596	0	5,147	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	95,011,490	2,104,026	113,270	4,171,639	49,450	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	14,830,563	19,788	589,795	39,233	257,481	192.00
192.01	19201	PEDIATRICS	401,660	31,304	0	62,067	0	192.01
192.02	19202	BROOKVILLE	2,904,495	1,464	164,645	2,902	71,878	192.02
192.03	19203	RADIOLOGY - OSGOOD	98,717	0	3,117	0	1,361	192.03
192.04	19204	ENT	0	0	0	0	0	192.04
194.00	07950	COMMUNITY RELATIONS	832,308	4,184	0	8,296	0	194.00
194.01	07951	COMMUNITY BENEFITS	707,584	19,028	0	37,728	0	194.01
194.02	07952	OTHER NON-REIMBURSABLE	0	0	0	0	0	194.02
194.03	07953	EMS	189,065	0	0	0	0	194.03
194.04	07954	BATESVILLE TOOL & DIE CLINIC	225,104	0	0	0	0	194.04
194.05	07955	MMHCB RHC	0	0	0	0	0	194.05
194.06	07956	FOUNDATION	284,271	5,427	0	10,760	0	194.06
194.07	07957	FQHC	0	0	0	0	0	194.07
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	115,485,257	2,185,221	870,827	4,332,625	380,170	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1329 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part I | Date/Time Prepared: 5/26/2023 12:48 pm

		Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	OPERATION OF PLANT -OFFSITE	
			4.00	4A	5.00	7.00	7.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-OFFSITE BLDG						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	18,375,602					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,489,254	18,360,546	18,360,546			5.00
7.00	00700	OPERATION OF PLANT	0	2,763,743	522,461	3,286,204		7.00
7.01	00701	OPERATION OF PLANT -OFFSITE	0	435,293	82,288	0	517,581	7.01
7.02	00702	OPERATION OF PLANT - HOSPITAL & OFFS	210,665	822,742	155,532	0	0	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	52,469	339,799	64,236	56,146	0	8.00
9.00	00900	HOUSEKEEPING	318,855	1,701,508	321,655	64,051	0	9.00
10.00	01000	DIETARY	31,753	233,333	44,110	48,179	0	10.00
11.00	01100	CAFETERIA	171,563	1,051,951	198,862	136,818	0	11.00
13.00	01300	NURSING ADMINISTRATION	541,682	4,077,758	770,863	1,906	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	31,179	5,894	23,652	0	14.00
15.00	01500	PHARMACY	233,999	4,445,932	840,463	18,872	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	305,054	1,306,924	247,062	86,546	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	974,099	4,429,934	837,439	464,383	0	30.00
31.00	03100	INTENSIVE CARE UNIT	126,919	547,897	103,575	43,398	0	31.00
43.00	04300	NURSERY	237,032	984,033	186,023	23,027	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	655,224	3,138,728	593,348	122,290	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	46,374	226,015	42,726	38,555	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,303,788	13,955,197	2,638,104	611,572	0	54.00
60.00	06000	LABORATORY	641,430	5,108,815	965,775	108,730	0	60.00
65.00	06500	RESPIRATORY THERAPY	303,481	1,378,472	260,588	83,141	0	65.00
66.00	06600	PHYSICAL THERAPY	375,077	1,681,371	317,848	174,093	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	112,802	478,146	90,389	36,524	0	67.00
68.00	06800	SPEECH PATHOLOGY	56,091	258,881	48,939	33,369	0	68.00
69.00	06900	ELECTROCARDIOLOGY	229,373	1,121,414	211,993	75,299	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,292,214	622,363	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	2,057,796	389,008	104,262	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	515,617	2,227,552	421,099	0	29,970	88.00
88.01	08801	MEDICAL ARTS CENTER	533,986	2,234,717	422,453	0	37,352	88.01
90.00	09000	CLINIC	910,250	2,900,905	548,390	437,825	0	90.00
90.01	09001	WOUND CLINC	124,639	452,429	85,528	24,652	0	90.01
90.02	09002	BEHAVIORAL HEALTH	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	829,721	4,563,619	862,711	279,323	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0				92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	244,791	1,272,575	240,569	5,874	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	12,575,988	87,881,418	13,142,294	3,102,487	67,322	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	4,261,875	19,998,735	3,780,576	44,773	350,548	192.00
192.01	19201	PEDIATRICS	131,516	626,547	118,443	70,831	0	192.01
192.02	19202	BROOKVILLE	948,008	4,093,392	773,819	3,312	97,858	192.02
192.03	19203	RADIOLOGY - OSGOOD	35,241	138,436	26,170	0	1,853	192.03
192.04	19204	ENT	0	0	0	0	0	192.04
194.00	07950	COMMUNITY RELATIONS	95,513	940,301	177,755	9,467	0	194.00
194.01	07951	COMMUNITY BENEFITS	185,411	949,751	179,542	43,055	0	194.01
194.02	07952	OTHER NON-REIMBURSABLE	0	0	0	0	0	194.02
194.03	07953	EMS	6,080	195,145	36,890	0	0	194.03
194.04	07954	BATESVILLE TOOL & DIE CLINIC	72,661	297,765	56,290	0	0	194.04
194.05	07955	MMHCB RHC	0	0	0	0	0	194.05
194.06	07956	FOUNDATION	63,309	363,767	68,767	12,279	0	194.06
194.07	07957	FQHC	0	0	0	0	0	194.07
200.00		Cross Foot Adjustments		0				200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	18,375,602	115,485,257	18,360,546	3,286,204	517,581	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1329 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part I | Date/Time Prepared: 5/26/2023 12:48 pm

		Cost Center Description	OPERATION OF PLANT - HOSPITAL & OFFS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.02	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-OFFSITE BLDG						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT -OFFSITE						7.01
7.02	00702	OPERATION OF PLANT - HOSPITAL & OFFS	978,274					7.02
8.00	00800	LAUNDRY & LINEN SERVICE	10,081	470,262				8.00
9.00	00900	HOUSEKEEPING	11,500	78,581	2,177,295			9.00
10.00	01000	DIETARY	8,650	121	29,659	364,052		10.00
11.00	01100	CAFETERIA	24,565	2,750	84,226	0	1,499,172	11.00
13.00	01300	NURSING ADMINISTRATION	342	0	1,173	0	37,531	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	4,247	0	14,560	0	0	14.00
15.00	01500	PHARMACY	3,388	0	11,617	0	38,113	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	15,539	0	53,278	0	92,857	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	83,377	95,078	285,876	347,898	227,968	30.00
31.00	03100	INTENSIVE CARE UNIT	7,792	4,841	26,716	16,154	27,113	31.00
43.00	04300	NURSERY	4,134	21,672	14,175	0	50,343	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	21,956	79,157	75,282	0	164,037	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	6,922	3,288	23,735	0	9,836	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	109,805	78,565	376,487	0	158,925	54.00
60.00	06000	LABORATORY	19,522	0	66,935	0	184,032	60.00
65.00	06500	RESPIRATORY THERAPY	14,927	3,223	51,182	0	39,472	65.00
66.00	06600	PHYSICAL THERAPY	31,257	20,481	107,172	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	6,558	4,547	22,485	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	5,991	2,670	20,542	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	13,519	9,746	46,354	0	50,796	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	18,720	0	64,184	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	616	0	0	0	88.00
88.01	08801	MEDICAL ARTS CENTER	0	324	0	0	0	88.01
90.00	09000	CLINIC	78,609	17,685	269,527	0	0	90.00
90.01	09001	WOUND CLINC	4,426	461	15,176	0	0	90.01
90.02	09002	BEHAVIORAL HEALTH	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	50,151	36,267	171,952	0	181,508	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	1,055	0	3,616	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	557,033	460,073	1,835,909	364,052	1,262,531	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	302,073	286	255,851	0	132,071	192.00
192.01	19201	PEDIATRICS	12,717	0	43,604	0	24,460	192.01
192.02	19202	BROOKVILLE	94,816	9,820	2,039	0	0	192.02
192.03	19203	RADIOLOGY - OSGOOD	0	74	0	0	0	192.03
192.04	19204	ENT	0	0	0	0	0	192.04
194.00	07950	COMMUNITY RELATIONS	1,700	0	5,828	0	19,866	194.00
194.01	07951	COMMUNITY BENEFITS	7,730	0	26,505	0	45,296	194.01
194.02	07952	OTHER NON-REIMBURSABLE	0	0	0	0	0	194.02
194.03	07953	EMS	0	0	0	0	2,006	194.03
194.04	07954	BATESVILLE TOOL & DIE CLINIC	0	9	0	0	0	194.04
194.05	07955	MMHCB RHC	0	0	0	0	0	194.05
194.06	07956	FOUNDATION	2,205	0	7,559	0	12,942	194.06
194.07	07957	FQHC	0	0	0	0	0	194.07
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)	978,274	470,262	2,177,295	364,052	1,499,172	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1329 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part I | Date/Time Prepared: 5/26/2023 12:48 pm

		Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	
			13.00	14.00	15.00	16.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-OFFSITE BLDG						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT -OFFSITE						7.01
7.02	00702	OPERATION OF PLANT - HOSPITAL & OFFS						7.02
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	4,889,573					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	79,532				14.00
15.00	01500	PHARMACY	194,219	0	5,552,604			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	1,802,206		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,177,213	0	0	1,185,662	9,134,828	30.00
31.00	03100	INTENSIVE CARE UNIT	138,062	0	0	0	915,548	31.00
43.00	04300	NURSERY	256,413	0	0	0	1,539,820	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	132,794	4,327,592	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	50,167	0	0	0	401,244	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	809,597	0	0	241,875	18,980,127	54.00
60.00	06000	LABORATORY	937,296	0	0	0	7,391,105	60.00
65.00	06500	RESPIRATORY THERAPY	201,159	0	0	0	2,032,164	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	2,332,222	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	638,649	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	370,392	68.00
69.00	06900	ELECTROCARDIOLOGY	201,017	0	0	14,228	1,744,366	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	79,532	0	0	3,994,109	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	2,633,970	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	5,552,604	0	5,552,604	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	2,679,237	88.00
88.01	08801	MEDICAL ARTS CENTER	0	0	0	0	2,694,846	88.01
90.00	09000	CLINIC	0	0	0	66,397	4,319,338	90.00
90.01	09001	WOUND CLINC	0	0	0	0	582,672	90.01
90.02	09002	BEHAVIORAL HEALTH	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	924,430	0	0	147,022	7,216,983	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	1,523,689	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	4,889,573	79,532	5,552,604	1,787,978	81,005,505	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	14,228	24,879,141	192.00
192.01	19201	PEDIATRICS	0	0	0	0	896,602	192.01
192.02	19202	BROOKVILLE	0	0	0	0	5,075,056	192.02
192.03	19203	RADIOLOGY - OSGOOD	0	0	0	0	166,533	192.03
192.04	19204	ENT	0	0	0	0	0	192.04
194.00	07950	COMMUNITY RELATIONS	0	0	0	0	1,154,917	194.00
194.01	07951	COMMUNITY BENEFITS	0	0	0	0	1,251,879	194.01
194.02	07952	OTHER NON-REIMBURSABLE	0	0	0	0	0	194.02
194.03	07953	EMS	0	0	0	0	234,041	194.03
194.04	07954	BATESVILLE TOOL & DIE CLINIC	0	0	0	0	354,064	194.04
194.05	07955	MMHCB RHC	0	0	0	0	0	194.05
194.06	07956	FOUNDATION	0	0	0	0	467,519	194.06
194.07	07957	FQHC	0	0	0	0	0	194.07
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	4,889,573	79,532	5,552,604	1,802,206	115,485,257	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1329 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part I | Date/Time Prepared: 5/26/2023 12:48 pm

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
1.01	00101	NEW CAP REL COSTS-OFFSITE BLDG				1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP				2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT				2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
7.01	00701	OPERATION OF PLANT -OFFSITE				7.01
7.02	00702	OPERATION OF PLANT - HOSPITAL & OFFS				7.02
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	0	9,134,828		30.00
31.00	03100	INTENSIVE CARE UNIT	0	915,548		31.00
43.00	04300	NURSERY	0	1,539,820		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	4,327,592		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	401,244		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	18,980,127		54.00
60.00	06000	LABORATORY	0	7,391,105		60.00
65.00	06500	RESPIRATORY THERAPY	0	2,032,164		65.00
66.00	06600	PHYSICAL THERAPY	0	2,332,222		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	638,649		67.00
68.00	06800	SPEECH PATHOLOGY	0	370,392		68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,744,366		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,994,109		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	2,633,970		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	5,552,604		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	2,679,237		88.00
88.01	08801	MEDICAL ARTS CENTER	0	2,694,846		88.01
90.00	09000	CLINIC	0	4,319,338		90.00
90.01	09001	WOUND CLINC	0	582,672		90.01
90.02	09002	BEHAVIORAL HEALTH	0	0		90.02
91.00	09100	EMERGENCY	0	7,216,983		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0			92.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	0		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
116.00	11600	HOSPICE	0	1,523,689		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	81,005,505		118.00
		NONREIMBURSABLE COST CENTERS				
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	24,879,141		192.00
192.01	19201	PEDIATRICS	0	896,602		192.01
192.02	19202	BROOKVILLE	0	5,075,056		192.02
192.03	19203	RADIOLOGY - OSGOOD	0	166,533		192.03
192.04	19204	ENT	0	0		192.04
194.00	07950	COMMUNITY RELATIONS	0	1,154,917		194.00
194.01	07951	COMMUNITY BENEFITS	0	1,251,879		194.01
194.02	07952	OTHER NON-REIMBURSABLE	0	0		194.02
194.03	07953	EMS	0	234,041		194.03
194.04	07954	BATESVILLE TOOL & DIE CLINIC	0	354,064		194.04
194.05	07955	MMHCB RHC	0	0		194.05
194.06	07956	FOUNDATION	0	467,519		194.06
194.07	07957	FQHC	0	0		194.07
200.00		Cross Foot Adjustments	0	0		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	0	115,485,257		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1329 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part II Date/Time Prepared: 5/26/2023 12:48 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	NEW OFFSITE BLDG	NEW MVBLE EQUIP	NEW MVBLE EQUIP OFFSIT	
			0	1.00	1.01	2.00	2.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-OFFSITE BLDG						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	9,349	0	18,535	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	327,102	0	648,543	0	5.00
7.00	00700	OPERATION OF PLANT	0	396,398	0	785,927	0	7.00
7.01	00701	OPERATION OF PLANT -OFFSITE	0	0	0	0	0	7.01
7.02	00702	OPERATION OF PLANT - HOSPITAL & OFFS	0	0	0	0	0	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	0	24,814	0	49,199	0	8.00
9.00	00900	HOUSEKEEPING	0	28,308	0	56,126	0	9.00
10.00	01000	DIETARY	0	21,293	0	42,218	0	10.00
11.00	01100	CAFETERIA	0	60,469	0	119,891	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	842	0	1,670	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	10,453	0	20,726	0	14.00
15.00	01500	PHARMACY	0	8,340	0	16,537	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	38,250	0	75,839	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	205,239	0	406,927	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	19,180	0	38,029	0	31.00
43.00	04300	NURSERY	0	10,177	0	20,178	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	54,047	0	107,160	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	17,040	0	33,785	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	270,292	0	535,907	0	54.00
60.00	06000	LABORATORY	0	48,054	0	95,277	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	36,745	0	72,854	0	65.00
66.00	06600	PHYSICAL THERAPY	0	76,942	0	152,553	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	16,142	0	32,006	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	14,748	0	29,240	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	33,279	0	65,982	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	46,080	0	91,362	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	50,425	0	22,014	88.00
88.01	08801	MEDICAL ARTS CENTER	0	0	62,845	0	27,436	88.01
90.00	09000	CLINIC	0	193,502	0	383,655	0	90.00
90.01	09001	WOUND CLINC	0	10,895	0	21,602	0	90.01
90.02	09002	BEHAVIORAL HEALTH	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	0	123,450	0	244,764	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	2,596	0	5,147	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	2,104,026	113,270	4,171,639	49,450	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	19,788	589,795	39,233	257,481	192.00
192.01	19201	PEDIATRICS	0	31,304	0	62,067	0	192.01
192.02	19202	BROOKVILLE	0	1,464	164,645	2,902	71,878	192.02
192.03	19203	RADIOLOGY - OSGOOD	0	0	3,117	0	1,361	192.03
192.04	19204	ENT	0	0	0	0	0	192.04
194.00	07950	COMMUNITY RELATIONS	0	4,184	0	8,296	0	194.00
194.01	07951	COMMUNITY BENEFITS	0	19,028	0	37,728	0	194.01
194.02	07952	OTHER NON-REIMBURSABLE	0	0	0	0	0	194.02
194.03	07953	EMS	0	0	0	0	0	194.03
194.04	07954	BATESVILLE TOOL & DIE CLINIC	0	0	0	0	0	194.04
194.05	07955	MMHCB RHC	0	0	0	0	0	194.05
194.06	07956	FOUNDATION	0	5,427	0	10,760	0	194.06
194.07	07957	FQHC	0	0	0	0	0	194.07
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	2,185,221	870,827	4,332,625	380,170	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1329 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part II | Date/Time Prepared: 5/26/2023 12:48 pm

		Cost Center Description	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	OPERATION OF PLANT -OFFSITE	
			2A	4.00	5.00	7.00	7.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-OFFSITE BLDG						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	27,884	27,884				4.00
5.00	00500	ADMINISTRATIVE & GENERAL	975,645	3,779	979,424			5.00
7.00	00700	OPERATION OF PLANT	1,182,325	0	27,870	1,210,195		7.00
7.01	00701	OPERATION OF PLANT -OFFSITE	0	0	4,389	0	4,389	7.01
7.02	00702	OPERATION OF PLANT - HOSPITAL & OFFS	0	320	8,297	0	0	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	74,013	80	3,427	20,677	0	8.00
9.00	00900	HOUSEKEEPING	84,434	484	17,158	23,588	0	9.00
10.00	01000	DIETARY	63,511	48	2,353	17,743	0	10.00
11.00	01100	CAFETERIA	180,360	260	10,608	50,385	0	11.00
13.00	01300	NURSING ADMINISTRATION	2,512	822	41,120	702	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	31,179	0	314	8,710	0	14.00
15.00	01500	PHARMACY	24,877	355	44,833	6,950	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	114,089	463	13,179	31,872	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	612,166	1,479	44,671	171,016	0	30.00
31.00	03100	INTENSIVE CARE UNIT	57,209	193	5,525	15,982	0	31.00
43.00	04300	NURSERY	30,355	360	9,923	8,480	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	161,207	995	31,651	45,035	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	50,825	70	2,279	14,199	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	806,199	1,979	140,724	225,222	0	54.00
60.00	06000	LABORATORY	143,331	974	51,517	40,041	0	60.00
65.00	06500	RESPIRATORY THERAPY	109,599	461	13,901	30,618	0	65.00
66.00	06600	PHYSICAL THERAPY	229,495	569	16,955	64,112	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	48,148	171	4,822	13,451	0	67.00
68.00	06800	SPEECH PATHOLOGY	43,988	85	2,611	12,289	0	68.00
69.00	06900	ELECTROCARDIOLOGY	99,261	348	11,308	27,730	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	33,199	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	137,442	0	20,751	38,396	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	72,439	783	22,463	0	254	88.00
88.01	08801	MEDICAL ARTS CENTER	90,281	811	22,535	0	317	88.01
90.00	09000	CLINIC	577,157	1,382	29,253	161,236	0	90.00
90.01	09001	WOUND CLINC	32,497	189	4,562	9,078	0	90.01
90.02	09002	BEHAVIORAL HEALTH	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	368,214	1,260	46,020	102,865	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0					92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	7,743	372	12,833	2,163	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	6,438,385	19,092	701,051	1,142,540	571	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	906,297	6,458	201,683	16,488	2,972	192.00
192.01	19201	PEDIATRICS	93,371	200	6,318	26,084	0	192.01
192.02	19202	BROOKVILLE	240,889	1,439	41,278	1,220	830	192.02
192.03	19203	RADIOLOGY - OSGOOD	4,478	54	1,396	0	16	192.03
192.04	19204	ENT	0	0	0	0	0	192.04
194.00	07950	COMMUNITY RELATIONS	12,480	145	9,482	3,486	0	194.00
194.01	07951	COMMUNITY BENEFITS	56,756	281	9,577	15,855	0	194.01
194.02	07952	OTHER NON-REIMBURSABLE	0	0	0	0	0	194.02
194.03	07953	EMS	0	9	1,968	0	0	194.03
194.04	07954	BATESVILLE TOOL & DIE CLINIC	0	110	3,003	0	0	194.04
194.05	07955	MMHCB RHC	0	0	0	0	0	194.05
194.06	07956	FOUNDATION	16,187	96	3,668	4,522	0	194.06
194.07	07957	FQHC	0	0	0	0	0	194.07
200.00		Cross Foot Adjustments	0					200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	7,768,843	27,884	979,424	1,210,195	4,389	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1329 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part II | Date/Time Prepared: 5/26/2023 12:48 pm

		Cost Center Description	OPERATION OF PLANT - HOSPITAL & OFFS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.02	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-OFFSITE BLDG						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT -OFFSITE						7.01
7.02	00702	OPERATION OF PLANT - HOSPITAL & OFFS	8,617					7.02
8.00	00800	LAUNDRY & LINEN SERVICE	89	98,286				8.00
9.00	00900	HOUSEKEEPING	101	16,424	142,189			9.00
10.00	01000	DIETARY	76	25	1,937	85,693		10.00
11.00	01100	CAFETERIA	216	575	5,500	0	247,904	11.00
13.00	01300	NURSING ADMINISTRATION	3	0	77	0	6,206	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	37	0	951	0	0	14.00
15.00	01500	PHARMACY	30	0	759	0	6,302	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	137	0	3,479	0	15,355	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	734	19,872	18,669	81,891	37,698	30.00
31.00	03100	INTENSIVE CARE UNIT	69	1,012	1,745	3,802	4,483	31.00
43.00	04300	NURSERY	36	4,529	926	0	8,325	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	193	16,544	4,916	0	27,125	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	61	687	1,550	0	1,626	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	967	16,420	24,586	0	26,280	54.00
60.00	06000	LABORATORY	172	0	4,371	0	30,432	60.00
65.00	06500	RESPIRATORY THERAPY	131	674	3,342	0	6,527	65.00
66.00	06600	PHYSICAL THERAPY	275	4,281	6,999	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	58	950	1,468	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	53	558	1,342	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	119	2,037	3,027	0	8,400	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	165	0	4,192	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	129	0	0	0	88.00
88.01	08801	MEDICAL ARTS CENTER	0	68	0	0	0	88.01
90.00	09000	CLINIC	692	3,696	17,602	0	0	90.00
90.01	09001	WOUND CLINC	39	96	991	0	0	90.01
90.02	09002	BEHAVIORAL HEALTH	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	442	7,580	11,229	0	30,014	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	9	0	236	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	4,904	96,157	119,894	85,693	208,773	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,664	60	16,708	0	21,839	192.00
192.01	19201	PEDIATRICS	112	0	2,848	0	4,045	192.01
192.02	19202	BROOKVILLE	835	2,052	133	0	0	192.02
192.03	19203	RADIOLOGY - OSGOOD	0	15	0	0	0	192.03
192.04	19204	ENT	0	0	0	0	0	192.04
194.00	07950	COMMUNITY RELATIONS	15	0	381	0	3,285	194.00
194.01	07951	COMMUNITY BENEFITS	68	0	1,731	0	7,490	194.01
194.02	07952	OTHER NON-REIMBURSABLE	0	0	0	0	0	194.02
194.03	07953	EMS	0	0	0	0	332	194.03
194.04	07954	BATESVILLE TOOL & DIE CLINIC	0	2	0	0	0	194.04
194.05	07955	MMHCB RHC	0	0	0	0	0	194.05
194.06	07956	FOUNDATION	19	0	494	0	2,140	194.06
194.07	07957	FQHC	0	0	0	0	0	194.07
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)	8,617	98,286	142,189	85,693	247,904	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1329 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part II | Date/Time Prepared: 5/26/2023 12:48 pm

		Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	
			13.00	14.00	15.00	16.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-OFFSITE BLDG						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT -OFFSITE						7.01
7.02	00702	OPERATION OF PLANT - HOSPITAL & OFFS						7.02
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	51,442					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	41,191				14.00
15.00	01500	PHARMACY	2,043	0	86,149			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	178,574		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	12,384	0	0	117,482	1,118,062	30.00
31.00	03100	INTENSIVE CARE UNIT	1,453	0	0	0	91,473	31.00
43.00	04300	NURSERY	2,698	0	0	0	65,632	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	13,158	300,824	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	528	0	0	0	71,825	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,518	0	0	23,967	1,274,862	54.00
60.00	06000	LABORATORY	9,861	0	0	0	280,699	60.00
65.00	06500	RESPIRATORY THERAPY	2,116	0	0	0	167,369	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	322,686	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	69,068	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	60,926	68.00
69.00	06900	ELECTROCARDIOLOGY	2,115	0	0	1,410	155,755	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	41,191	0	0	74,390	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	200,946	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	86,149	0	86,149	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	96,068	88.00
88.01	08801	MEDICAL ARTS CENTER	0	0	0	0	114,012	88.01
90.00	09000	CLINIC	0	0	0	6,579	797,597	90.00
90.01	09001	WOUND CLINC	0	0	0	0	47,452	90.01
90.02	09002	BEHAVIORAL HEALTH	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	9,726	0	0	14,568	591,918	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	23,356	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	51,442	41,191	86,149	177,164	6,011,069	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	1,410	1,176,579	192.00
192.01	19201	PEDIATRICS	0	0	0	0	132,978	192.01
192.02	19202	BROOKVILLE	0	0	0	0	288,676	192.02
192.03	19203	RADIOLOGY - OSGOOD	0	0	0	0	5,959	192.03
192.04	19204	ENT	0	0	0	0	0	192.04
194.00	07950	COMMUNITY RELATIONS	0	0	0	0	29,274	194.00
194.01	07951	COMMUNITY BENEFITS	0	0	0	0	91,758	194.01
194.02	07952	OTHER NON-REIMBURSABLE	0	0	0	0	0	194.02
194.03	07953	EMS	0	0	0	0	2,309	194.03
194.04	07954	BATESVILLE TOOL & DIE CLINIC	0	0	0	0	3,115	194.04
194.05	07955	MMHCB RHC	0	0	0	0	0	194.05
194.06	07956	FOUNDATION	0	0	0	0	27,126	194.06
194.07	07957	FQHC	0	0	0	0	0	194.07
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	51,442	41,191	86,149	178,574	7,768,843	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1329 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part II Date/Time Prepared: 5/26/2023 12:48 pm

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
1.01	00101	NEW CAP REL COSTS-OFFSITE BLDG				1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP				2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT				2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
7.01	00701	OPERATION OF PLANT -OFFSITE				7.01
7.02	00702	OPERATION OF PLANT - HOSPITAL & OFFS				7.02
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	0	1,118,062		30.00
31.00	03100	INTENSIVE CARE UNIT	0	91,473		31.00
43.00	04300	NURSERY	0	65,632		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	300,824		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	71,825		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,274,862		54.00
60.00	06000	LABORATORY	0	280,699		60.00
65.00	06500	RESPIRATORY THERAPY	0	167,369		65.00
66.00	06600	PHYSICAL THERAPY	0	322,686		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	69,068		67.00
68.00	06800	SPEECH PATHOLOGY	0	60,926		68.00
69.00	06900	ELECTROCARDIOLOGY	0	155,755		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	74,390		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	200,946		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	86,149		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	96,068		88.00
88.01	08801	MEDICAL ARTS CENTER	0	114,012		88.01
90.00	09000	CLINIC	0	797,597		90.00
90.01	09001	WOUND CLINC	0	47,452		90.01
90.02	09002	BEHAVIORAL HEALTH	0	0		90.02
91.00	09100	EMERGENCY	0	591,918		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0			92.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	0		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
116.00	11600	HOSPICE	0	23,356		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	6,011,069		118.00
		NONREIMBURSABLE COST CENTERS				
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,176,579		192.00
192.01	19201	PEDIATRICS	0	132,978		192.01
192.02	19202	BROOKVILLE	0	288,676		192.02
192.03	19203	RADIOLOGY - OSGOOD	0	5,959		192.03
192.04	19204	ENT	0	0		192.04
194.00	07950	COMMUNITY RELATIONS	0	29,274		194.00
194.01	07951	COMMUNITY BENEFITS	0	91,758		194.01
194.02	07952	OTHER NON-REIMBURSABLE	0	0		194.02
194.03	07953	EMS	0	2,309		194.03
194.04	07954	BATESVILLE TOOL & DIE CLINIC	0	3,115		194.04
194.05	07955	MMHCB RHC	0	0		194.05
194.06	07956	FOUNDATION	0	27,126		194.06
194.07	07957	FQHC	0	0		194.07
200.00		Cross Foot Adjustments	0	0		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	0	7,768,843		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1329 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B-1 | Date/Time Prepared: 5/26/2023 12:48 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			NEW BLDG & FIXT (SQUARE FEET)	NEW OFFSITE BLDG (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)	NEW MVBLE EQUIP OFFSIT (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	
			1.00	1.01	2.00	2.01	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	158,249					1.00
1.01	00101	NEW CAP REL COSTS-OFFSITE BLDG	0	88,836				1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP			158,249			2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT			0	88,836		2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	677	0	677	0	51,473,300	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	23,688	0	23,688	0	6,972,836	5.00
7.00	00700	OPERATION OF PLANT	28,706	0	28,706	0	0	7.00
7.01	00701	OPERATION OF PLANT -OFFSITE	0	0	0	0	0	7.01
7.02	00702	OPERATION OF PLANT - HOSPITAL & OFFS	0	0	0	0	590,111	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	1,797	0	1,797	0	146,976	8.00
9.00	00900	HOUSEKEEPING	2,050	0	2,050	0	893,170	9.00
10.00	01000	DIETARY	1,542	0	1,542	0	88,946	10.00
11.00	01100	CAFETERIA	4,379	0	4,379	0	480,578	11.00
13.00	01300	NURSING ADMINISTRATION	61	0	61	0	1,517,347	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	757	0	757	0	0	14.00
15.00	01500	PHARMACY	604	0	604	0	655,473	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,770	0	2,770	0	854,509	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	14,863	0	14,863	0	2,728,621	30.00
31.00	03100	INTENSIVE CARE UNIT	1,389	0	1,389	0	355,521	31.00
43.00	04300	NURSERY	737	0	737	0	663,969	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,914	0	3,914	0	1,835,396	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,234	0	1,234	0	129,903	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	19,574	0	19,574	0	3,652,140	54.00
60.00	06000	LABORATORY	3,480	0	3,480	0	1,796,759	60.00
65.00	06500	RESPIRATORY THERAPY	2,661	0	2,661	0	850,104	65.00
66.00	06600	PHYSICAL THERAPY	5,572	0	5,572	0	1,050,657	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,169	0	1,169	0	315,977	67.00
68.00	06800	SPEECH PATHOLOGY	1,068	0	1,068	0	157,120	68.00
69.00	06900	ELECTROCARDIOLOGY	2,410	0	2,410	0	642,515	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	3,337	0	3,337	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	5,144	0	5,144	1,444,335	88.00
88.01	08801	MEDICAL ARTS CENTER	0	6,411	0	6,411	1,495,789	88.01
90.00	09000	CLINIC	14,013	0	14,013	0	2,549,771	90.00
90.01	09001	WOUND CLINC	789	0	789	0	349,136	90.01
90.02	09002	BEHAVIORAL HEALTH	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	8,940	0	8,940	0	2,324,194	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	188	0	188	0	685,703	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	152,369	11,555	152,369	11,555	35,227,556	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,433	60,167	1,433	60,167	11,938,267	192.00
192.01	19201	PEDIATRICS	2,267	0	2,267	0	368,399	192.01
192.02	19202	BROOKVILLE	106	16,796	106	16,796	2,655,536	192.02
192.03	19203	RADIOLOGY - OSGOOD	0	318	0	318	98,717	192.03
192.04	19204	ENT	0	0	0	0	0	192.04
194.00	07950	COMMUNITY RELATIONS	303	0	303	0	267,548	194.00
194.01	07951	COMMUNITY BENEFITS	1,378	0	1,378	0	519,369	194.01
194.02	07952	OTHER NON-REIMBURSABLE	0	0	0	0	0	194.02
194.03	07953	EMS	0	0	0	0	17,032	194.03
194.04	07954	BATESVILLE TOOL & DIE CLINIC	0	0	0	0	203,536	194.04
194.05	07955	MMHCB RHC	0	0	0	0	0	194.05
194.06	07956	FOUNDATION	393	0	393	0	177,340	194.06
194.07	07957	FQHC	0	0	0	0	0	194.07
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,185,221	870,827	4,332,625	380,170	18,375,602	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	13.808751	9.802636	27.378530	4.279459	0.356993	203.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1329 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B-1 | Date/Time Prepared: 5/26/2023 12:48 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			NEW BLDG & FIXT (SQUARE FEET)	NEW OFFSITE BLDG (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)	NEW MVBLE EQUIP OFFSIT (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	
			1.00	1.01	2.00	2.01	4.00	
204.00		Cost to be allocated (per Wkst. B, Part II)					27,884	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)					0.000542	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: 15-1329 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B-1 | Date/Time Prepared: 5/26/2023 12:48 pm

		Cost Center Description	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	OPERATION OF PLANT -OFFSITE (SQUARE FEET)	OPERATION OF PLANT - HOSPITAL & OFFS (SQUARE FEET)	
			5A	5.00	7.00	7.01	7.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-OFFSITE BLDG						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-18,360,546	97,124,711				5.00
7.00	00700	OPERATION OF PLANT	0	2,763,743	105,178			7.00
7.01	00701	OPERATION OF PLANT -OFFSITE	0	435,293	0	88,836		7.01
7.02	00702	OPERATION OF PLANT - HOSPITAL & OFFS	0	822,742	0	0	174,389	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	0	339,799	1,797	0	1,797	8.00
9.00	00900	HOUSEKEEPING	0	1,701,508	2,050	0	2,050	9.00
10.00	01000	DIETARY	0	233,333	1,542	0	1,542	10.00
11.00	01100	CAFETERIA	0	1,051,951	4,379	0	4,379	11.00
13.00	01300	NURSING ADMINISTRATION	0	4,077,758	61	0	61	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	31,179	757	0	757	14.00
15.00	01500	PHARMACY	0	4,445,932	604	0	604	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,306,924	2,770	0	2,770	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	4,429,934	14,863	0	14,863	30.00
31.00	03100	INTENSIVE CARE UNIT	0	547,897	1,389	0	1,389	31.00
43.00	04300	NURSERY	0	984,033	737	0	737	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	3,138,728	3,914	0	3,914	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	226,015	1,234	0	1,234	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	13,955,197	19,574	0	19,574	54.00
60.00	06000	LABORATORY	0	5,108,815	3,480	0	3,480	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,378,472	2,661	0	2,661	65.00
66.00	06600	PHYSICAL THERAPY	0	1,681,371	5,572	0	5,572	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	478,146	1,169	0	1,169	67.00
68.00	06800	SPEECH PATHOLOGY	0	258,881	1,068	0	1,068	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,121,414	2,410	0	2,410	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,292,214	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	2,057,796	3,337	0	3,337	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	2,227,552	0	5,144	0	88.00
88.01	08801	MEDICAL ARTS CENTER	0	2,234,717	0	6,411	0	88.01
90.00	09000	CLINIC	0	2,900,905	14,013	0	14,013	90.00
90.01	09001	WOUND CLINC	0	452,429	789	0	789	90.01
90.02	09002	BEHAVIORAL HEALTH	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	0	4,563,619	8,940	0	8,940	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	1,272,575	188	0	188	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-18,360,546	69,520,872	99,298	11,555	99,298	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	19,998,735	1,433	60,167	53,848	192.00
192.01	19201	PEDIATRICS	0	626,547	2,267	0	2,267	192.01
192.02	19202	BROOKVILLE	0	4,093,392	106	16,796	16,902	192.02
192.03	19203	RADIOLOGY - OSGOOD	0	138,436	0	318	0	192.03
192.04	19204	ENT	0	0	0	0	0	192.04
194.00	07950	COMMUNITY RELATIONS	0	940,301	303	0	303	194.00
194.01	07951	COMMUNITY BENEFITS	0	949,751	1,378	0	1,378	194.01
194.02	07952	OTHER NON-REIMBURSABLE	0	0	0	0	0	194.02
194.03	07953	EMS	0	195,145	0	0	0	194.03
194.04	07954	BATESVILLE TOOL & DIE CLINIC	0	297,765	0	0	0	194.04
194.05	07955	MMHCB RHC	0	0	0	0	0	194.05
194.06	07956	FOUNDATION	0	363,767	393	0	393	194.06
194.07	07957	FQHC	0	0	0	0	0	194.07
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)		18,360,546	3,286,204	517,581	978,274	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)		0.189041	31.244215	5.826253	5.609723	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		979,424	1,210,195	4,389	8,617	204.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1329 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B-1 | Date/Time Prepared: 5/26/2023 12:48 pm

		Cost Center Description	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	OPERATION OF PLANT -OFFSITE (SQUARE FEET)	OPERATION OF PLANT - HOSPITAL & OFFS (SQUARE FEET)	
			5A	5.00	7.00	7.01	7.02	
205.00		Unit cost multiplier (Wkst. B, Part II)		0.010084	11.506161	0.049406	0.049413	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: 15-1329 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B-1 | Date/Time Prepared: 5/26/2023 12:48 pm

		Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (HOURS OF SERVICE)	
			8.00	9.00	10.00	11.00	13.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-OFFSITE BLDG						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT -OFFSITE						7.01
7.02	00702	OPERATION OF PLANT - HOSPITAL & OFFS						7.02
8.00	00800	LAUNDRY & LINEN SERVICE	355,132					8.00
9.00	00900	HOUSEKEEPING	59,343	113,200				9.00
10.00	01000	DIETARY	91	1,542	16,857			10.00
11.00	01100	CAFETERIA	2,077	4,379	0	23,168		11.00
13.00	01300	NURSING ADMINISTRATION	0	61	0	580	308,577	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	757	0	0	0	14.00
15.00	01500	PHARMACY	0	604	0	589	12,257	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	2,770	0	1,435	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	71,800	14,863	16,109	3,523	74,293	30.00
31.00	03100	INTENSIVE CARE UNIT	3,656	1,389	748	419	8,713	31.00
43.00	04300	NURSERY	16,366	737	0	778	16,182	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	59,778	3,914	0	2,535	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,483	1,234	0	152	3,166	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	59,331	19,574	0	2,456	51,093	54.00
60.00	06000	LABORATORY	0	3,480	0	2,844	59,152	60.00
65.00	06500	RESPIRATORY THERAPY	2,434	2,661	0	610	12,695	65.00
66.00	06600	PHYSICAL THERAPY	15,467	5,572	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,434	1,169	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	2,016	1,068	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	7,360	2,410	0	785	12,686	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	3,337	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	465	0	0	0	0	88.00
88.01	08801	MEDICAL ARTS CENTER	245	0	0	0	0	88.01
90.00	09000	CLINIC	13,355	14,013	0	0	0	90.00
90.01	09001	WOUND CLINC	348	789	0	0	0	90.01
90.02	09002	BEHAVIORAL HEALTH	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	27,388	8,940	0	2,805	58,340	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	188	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	347,437	95,451	16,857	19,511	308,577	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	216	13,302	0	2,041	0	192.00
192.01	19201	PEDIATRICS	0	2,267	0	378	0	192.01
192.02	19202	BROOKVILLE	7,416	106	0	0	0	192.02
192.03	19203	RADIOLOGY - OSGOOD	56	0	0	0	0	192.03
192.04	19204	ENT	0	0	0	0	0	192.04
194.00	07950	COMMUNITY RELATIONS	0	303	0	307	0	194.00
194.01	07951	COMMUNITY BENEFITS	0	1,378	0	700	0	194.01
194.02	07952	OTHER NON-REIMBURSABLE	0	0	0	0	0	194.02
194.03	07953	EMS	0	0	0	31	0	194.03
194.04	07954	BATESVILLE TOOL & DIE CLINIC	7	0	0	0	0	194.04
194.05	07955	MMHCB RHC	0	0	0	0	0	194.05
194.06	07956	FOUNDATION	0	393	0	200	0	194.06
194.07	07957	FQHC	0	0	0	0	0	194.07
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)	470,262	2,177,295	364,052	1,499,172	4,889,573	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	1.324189	19.234055	21.596488	64.708736	15.845552	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	98,286	142,189	85,693	247,904	51,442	204.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1329 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B-1 | Date/Time Prepared: 5/26/2023 12:48 pm

		Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (HOURS OF SERVICE)	
			8.00	9.00	10.00	11.00	13.00	
205.00		Unit cost multiplier (Wkst. B, Part II)	0.276759	1.256087	5.083526	10.700276	0.166707	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: 15-1329 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B-1 | Date/Time Prepared: 5/26/2023 12:48 pm

		Cost Center Description	CENTRAL SERVICES & SUPPLY (100% MED SUPPLIES)	PHARMACY (100% TO DRUGS)	MEDICAL RECORDS & LIBRARY (TIME SPENT)		
			14.00	15.00	16.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	NEW CAP REL COSTS-OFFSITE BLDG					1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT					2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
7.01	00701	OPERATION OF PLANT -OFFSITE					7.01
7.02	00702	OPERATION OF PLANT - HOSPITAL & OFFS					7.02
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	100				14.00
15.00	01500	PHARMACY	0	100			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	760		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	0	500		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0		31.00
43.00	04300	NURSERY	0	0	0		43.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	56		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	102		54.00
60.00	06000	LABORATORY	0	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	6		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	100	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	100	0		73.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
88.01	08801	MEDICAL ARTS CENTER	0	0	0		88.01
90.00	09000	CLINIC	0	0	28		90.00
90.01	09001	WOUND CLINC	0	0	0		90.01
90.02	09002	BEHAVIORAL HEALTH	0	0	0		90.02
91.00	09100	EMERGENCY	0	0	62		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
		OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	0	0	0		101.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	0	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	100	100	754		118.00
		NONREIMBURSABLE COST CENTERS					
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	6		192.00
192.01	19201	PEDIATRICS	0	0	0		192.01
192.02	19202	BROOKVILLE	0	0	0		192.02
192.03	19203	RADIOLOGY - OSGOOD	0	0	0		192.03
192.04	19204	ENT	0	0	0		192.04
194.00	07950	COMMUNITY RELATIONS	0	0	0		194.00
194.01	07951	COMMUNITY BENEFITS	0	0	0		194.01
194.02	07952	OTHER NON-REIMBURSABLE	0	0	0		194.02
194.03	07953	EMS	0	0	0		194.03
194.04	07954	BATESVILLE TOOL & DIE CLINIC	0	0	0		194.04
194.05	07955	MMHCB RHC	0	0	0		194.05
194.06	07956	FOUNDATION	0	0	0		194.06
194.07	07957	FQHC	0	0	0		194.07
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)	79,532	5,552,604	1,802,206		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	795.320000	55,526.040000	2,371.323684		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	41,191	86,149	178,574		204.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1329 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B-1 | Date/Time Prepared: 5/26/2023 12:48 pm

		Cost Center Description	CENTRAL SERVICES & SUPPLY (100% MED SUPPLIES)	PHARMACY (100% TO DRUGS)	MEDICAL RECORDS & LIBRARY (TIME SPENT)		
			14.00	15.00	16.00		
205.00		Unit cost multiplier (Wkst. B, Part II)	411.910000	861.490000	234.965789		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: 15-1329 | Period: From 01/01/2022 To 12/31/2022 | Worksheet C Part I Date/Time Prepared: 5/26/2023 12:48 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	9,134,828		9,134,828	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	915,548		915,548	0	0	31.00
43.00	04300	NURSERY	1,539,820		1,539,820	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,327,592		4,327,592	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	401,244		401,244	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	18,980,127		18,980,127	0	0	54.00
60.00	06000	LABORATORY	7,391,105		7,391,105	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	2,032,164	0	2,032,164	0	0	65.00
66.00	06600	PHYSICAL THERAPY	2,332,222	0	2,332,222	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	638,649	0	638,649	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	370,392	0	370,392	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,744,366		1,744,366	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,994,109		3,994,109	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	2,633,970		2,633,970	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,552,604		5,552,604	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,679,237		2,679,237	0	0	88.00
88.01	08801	MEDICAL ARTS CENTER	2,694,846		2,694,846	0	0	88.01
90.00	09000	CLINIC	4,319,338		4,319,338	0	0	90.00
90.01	09001	WOUND CLINC	582,672		582,672	0	0	90.01
90.02	09002	BEHAVIORAL HEALTH	0		0	0	0	90.02
91.00	09100	EMERGENCY	7,216,983		7,216,983	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,839,346		2,839,346		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	1,523,689		1,523,689		0	116.00
200.00		Subtotal (see instructions)	83,844,851	0	83,844,851	0	0	200.00
201.00		Less Observation Beds	2,839,346		2,839,346		0	201.00
202.00		Total (see instructions)	81,005,505	0	81,005,505	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1329 | Period: From 01/01/2022 To 12/31/2022 | Worksheet C Part I Date/Time Prepared: 5/26/2023 12:48 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	6,058,776		6,058,776			30.00
31.00	03100	INTENSIVE CARE UNIT	753,904		753,904			31.00
43.00	04300	NURSERY	2,413,318		2,413,318			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,158,745	11,022,385	13,181,130	0.328317	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	215,819	129,508	345,327	1.161925	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,758,655	101,655,433	103,414,088	0.183535	0.000000	54.00
60.00	06000	LABORATORY	3,973,851	46,907,080	50,880,931	0.145263	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	1,667,664	1,644,497	3,312,161	0.613546	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	157,302	4,620,656	4,777,958	0.488121	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	124,516	936,155	1,060,671	0.602118	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	49,259	573,648	622,907	0.594618	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	299,906	6,403,192	6,703,098	0.260233	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,852,853	10,462,704	13,315,557	0.299958	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	470,980	2,388,858	2,859,838	0.921021	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,390,581	11,021,291	15,411,872	0.360281	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	2,221,071	2,221,071			88.00
88.01	08801	MEDICAL ARTS CENTER	0	1,940,873	1,940,873			88.01
90.00	09000	CLINIC	1,000	7,572,081	7,573,081	0.570354	0.000000	90.00
90.01	09001	WOUND CLINC	0	1,795,252	1,795,252	0.324563	0.000000	90.01
90.02	09002	BEHAVIORAL HEALTH	0	0	0	0.000000	0.000000	90.02
91.00	09100	EMERGENCY	153,111	17,410,743	17,563,854	0.410900	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	116,571	4,178,805	4,295,376	0.661024	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	1,772,515	1,772,515			116.00
200.00		Subtotal (see instructions)	27,616,811	234,656,747	262,273,558			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	27,616,811	234,656,747	262,273,558			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1329 | Period: From 01/01/2022 To 12/31/2022 | Worksheet C Part I Date/Time Prepared: 5/26/2023 12:48 pm

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	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	MEDICAL ARTS CENTER			88.01
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	WOUND CLINC	0.000000		90.01
90.02	09002	BEHAVIORAL HEALTH	0.000000		90.02
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY			101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
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: 15-1329 | Period: From 01/01/2022 To 12/31/2022 | Worksheet C Part I Date/Time Prepared: 5/26/2023 12:48 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	9,134,828		9,134,828	0	9,134,828	30.00
31.00	03100	INTENSIVE CARE UNIT	915,548		915,548	0	915,548	31.00
43.00	04300	NURSERY	1,539,820		1,539,820	0	1,539,820	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,327,592		4,327,592	0	4,327,592	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	401,244		401,244	0	401,244	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	18,980,127		18,980,127	0	18,980,127	54.00
60.00	06000	LABORATORY	7,391,105		7,391,105	0	7,391,105	60.00
65.00	06500	RESPIRATORY THERAPY	2,032,164	0	2,032,164	0	2,032,164	65.00
66.00	06600	PHYSICAL THERAPY	2,332,222	0	2,332,222	0	2,332,222	66.00
67.00	06700	OCCUPATIONAL THERAPY	638,649	0	638,649	0	638,649	67.00
68.00	06800	SPEECH PATHOLOGY	370,392	0	370,392	0	370,392	68.00
69.00	06900	ELECTROCARDIOLOGY	1,744,366		1,744,366	0	1,744,366	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,994,109		3,994,109	0	3,994,109	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	2,633,970		2,633,970	0	2,633,970	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,552,604		5,552,604	0	5,552,604	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,679,237		2,679,237	0	2,679,237	88.00
88.01	08801	MEDICAL ARTS CENTER	2,694,846		2,694,846	0	2,694,846	88.01
90.00	09000	CLINIC	4,319,338		4,319,338	0	4,319,338	90.00
90.01	09001	WOUND CLINC	582,672		582,672	0	582,672	90.01
90.02	09002	BEHAVIORAL HEALTH	0		0	0	0	90.02
91.00	09100	EMERGENCY	7,216,983		7,216,983	0	7,216,983	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,839,346		2,839,346		2,839,346	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	1,523,689		1,523,689		1,523,689	116.00
200.00		Subtotal (see instructions)	83,844,851	0	83,844,851	0	83,844,851	200.00
201.00		Less Observation Beds	2,839,346		2,839,346		2,839,346	201.00
202.00		Total (see instructions)	81,005,505	0	81,005,505	0	81,005,505	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1329 | Period: From 01/01/2022 To 12/31/2022 | Worksheet C Part I Date/Time Prepared: 5/26/2023 12:48 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	6,058,776		6,058,776			30.00
31.00	03100	INTENSIVE CARE UNIT	753,904		753,904			31.00
43.00	04300	NURSERY	2,413,318		2,413,318			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,158,745	11,022,385	13,181,130	0.328317	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	215,819	129,508	345,327	1.161925	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,758,655	101,655,433	103,414,088	0.183535	0.000000	54.00
60.00	06000	LABORATORY	3,973,851	46,907,080	50,880,931	0.145263	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	1,667,664	1,644,497	3,312,161	0.613546	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	157,302	4,620,656	4,777,958	0.488121	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	124,516	936,155	1,060,671	0.602118	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	49,259	573,648	622,907	0.594618	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	299,906	6,403,192	6,703,098	0.260233	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,852,853	10,462,704	13,315,557	0.299958	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	470,980	2,388,858	2,859,838	0.921021	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,390,581	11,021,291	15,411,872	0.360281	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	2,221,071	2,221,071	1.206282	0.000000	88.00
88.01	08801	MEDICAL ARTS CENTER	0	1,940,873	1,940,873	1.388471	0.000000	88.01
90.00	09000	CLINIC	1,000	7,572,081	7,573,081	0.570354	0.000000	90.00
90.01	09001	WOUND CLINC	0	1,795,252	1,795,252	0.324563	0.000000	90.01
90.02	09002	BEHAVIORAL HEALTH	0	0	0	0.000000	0.000000	90.02
91.00	09100	EMERGENCY	153,111	17,410,743	17,563,854	0.410900	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	116,571	4,178,805	4,295,376	0.661024	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	1,772,515	1,772,515			116.00
200.00		Subtotal (see instructions)	27,616,811	234,656,747	262,273,558			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	27,616,811	234,656,747	262,273,558			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1329 | Period: From 01/01/2022 To 12/31/2022 | Worksheet C Part I Date/Time Prepared: 5/26/2023 12:48 pm

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	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	MEDICAL ARTS CENTER	0.000000		88.01
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	WOUND CLINC	0.000000		90.01
90.02	09002	BEHAVIORAL HEALTH	0.000000		90.02
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY			101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
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: 15-1329 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part II Date/Time Prepared: 5/26/2023 12:48 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	300,824	13,181,130	0.022822	486,886	11,112	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	71,825	345,327	0.207991	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,274,862	103,414,088	0.012328	460,503	5,677	54.00
60.00	06000	LABORATORY	280,699	50,880,931	0.005517	989,180	5,457	60.00
65.00	06500	RESPIRATORY THERAPY	167,369	3,312,161	0.050532	639,439	32,312	65.00
66.00	06600	PHYSICAL THERAPY	322,686	4,777,958	0.067536	78,089	5,274	66.00
67.00	06700	OCCUPATIONAL THERAPY	69,068	1,060,671	0.065117	58,112	3,784	67.00
68.00	06800	SPEECH PATHOLOGY	60,926	622,907	0.097809	27,901	2,729	68.00
69.00	06900	ELECTROCARDIOLOGY	155,755	6,703,098	0.023236	111,181	2,583	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	74,390	13,315,557	0.005587	774,428	4,327	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	200,946	2,859,838	0.070265	298,893	21,002	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	86,149	15,411,872	0.005590	1,255,306	7,017	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	96,068	2,221,071	0.043253	0	0	88.00
88.01	08801	MEDICAL ARTS CENTER	114,012	1,940,873	0.058743	0	0	88.01
90.00	09000	CLINIC	797,597	7,573,081	0.105320	0	0	90.00
90.01	09001	WOUND CLINC	47,452	1,795,252	0.026432	0	0	90.01
90.02	09002	BEHAVIORAL HEALTH	0	0	0.000000	0	0	90.02
91.00	09100	EMERGENCY	591,918	17,563,854	0.033701	7,138	241	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	347,525	4,295,376	0.080907	17,120	1,385	92.00
200.00		Total (lines 50 through 199)	5,060,071	251,275,045		5,204,176	102,900	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1329 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part IV | Date/Time Prepared: 5/26/2023 12:48 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	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	MEDICAL ARTS CENTER	0	0	0	0	0	88.01
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINC	0	0	0	0	0	90.01
90.02	09002	BEHAVIORAL HEALTH	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1329 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part IV Date/Time Prepared: 5/26/2023 12:48 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	13,181,130	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	345,327	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	103,414,088	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	50,880,931	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	3,312,161	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	4,777,958	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,060,671	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	622,907	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	6,703,098	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	13,315,557	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	2,859,838	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	15,411,872	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	2,221,071	0.000000	88.00
88.01	08801	MEDICAL ARTS CENTER	0	0	0	1,940,873	0.000000	88.01
90.00	09000	CLINIC	0	0	0	7,573,081	0.000000	90.00
90.01	09001	WOUND CLINC	0	0	0	1,795,252	0.000000	90.01
90.02	09002	BEHAVIORAL HEALTH	0	0	0	0	0.000000	90.02
91.00	09100	EMERGENCY	0	0	0	17,563,854	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	4,295,376	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	251,275,045		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1329 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part IV | Date/Time Prepared: 5/26/2023 12:48 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	486,886	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	460,503	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	989,180	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	639,439	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	78,089	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	58,112	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	27,901	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	111,181	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	774,428	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	298,893	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	1,255,306	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	MEDICAL ARTS CENTER	0.000000	0	0	0	0	88.01
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	WOUND CLINC	0.000000	0	0	0	0	90.01
90.02	09002	BEHAVIORAL HEALTH	0.000000	0	0	0	0	90.02
91.00	09100	EMERGENCY	0.000000	7,138	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	17,120	0	0	0	92.00
200.00		Total (lines 50 through 199)		5,204,176	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1329 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part V Date/Time Prepared: 5/26/2023 12:48 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	0.328317	0	2,634,612	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.161925	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.183535	0	35,348,641	1,452	0	54.00
60.00	06000	LABORATORY	0.145263	0	12,597,085	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.613546	0	441,577	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.488121	0	1,453,658	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.602118	0	222,385	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.594618	0	42,079	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.260233	0	1,809,587	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.299958	0	2,383,945	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.921021	0	604,144	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.360281	0	4,318,458	271	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC						88.00
88.01	08801	MEDICAL ARTS CENTER						88.01
90.00	09000	CLINIC	0.570354	0	1,957,217	162	0	90.00
90.01	09001	WOUND CLINC	0.324563	0	643,831	0	0	90.01
90.02	09002	BEHAVIORAL HEALTH	0.000000	0	0	0	0	90.02
91.00	09100	EMERGENCY	0.410900	0	3,825,423	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.661024	0	1,175,559	0	0	92.00
200.00		Subtotal (see instructions)		0	69,458,201	1,885	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	69,458,201	1,885	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1329 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part V Date/Time Prepared: 5/26/2023 12:48 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	864,988	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,487,713	266		54.00
60.00	06000	LABORATORY	1,829,890	0		60.00
65.00	06500	RESPIRATORY THERAPY	270,928	0		65.00
66.00	06600	PHYSICAL THERAPY	709,561	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	133,902	0		67.00
68.00	06800	SPEECH PATHOLOGY	25,021	0		68.00
69.00	06900	ELECTROCARDIOLOGY	470,914	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	715,083	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	556,429	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,555,858	98		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC				88.00
88.01	08801	MEDICAL ARTS CENTER				88.01
90.00	09000	CLINIC	1,116,307	92		90.00
90.01	09001	WOUND CLINC	208,964	0		90.01
90.02	09002	BEHAVIORAL HEALTH	0	0		90.02
91.00	09100	EMERGENCY	1,571,866	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	777,073	0		92.00
200.00		Subtotal (see instructions)	17,294,497	456		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	17,294,497	456		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1329 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-1 | Date/Time Prepared: 5/26/2023 12:48 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)	5,789	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	5,501	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	3,731	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	176	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	112	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)	1,369	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)	176	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)	9,134,828	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)	28,049	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)	310,379	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	8,824,449	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)	8,824,449	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)	1,604.15	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,196,081	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	2,196,081	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1329 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-1 | Date/Time Prepared: 5/26/2023 12:48 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	915,548	290	3,157.06	99	312,549	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	1,873,113	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)	4,381,743	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)	282,330	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	282,330	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	1,770	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,604.15	88.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-1329	Period: From 01/01/2022 To 12/31/2022	Worksheet D-1 Date/Time Prepared: 5/26/2023 12:48 pm
	Title XVIII	Hospital	Cost

	Cost Center Description		
		1.00	
89.00	Observation bed cost (line 87 x line 88) (see instructions)	2,839,346	89.00

	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	1,118,062	9,134,828	0.122396	2,839,346	347,525	90.00
91.00	Nursing Program cost	0	9,134,828	0.000000	2,839,346	0	91.00
92.00	Allied health cost	0	9,134,828	0.000000	2,839,346	0	92.00
93.00	All other Medical Education	0	9,134,828	0.000000	2,839,346	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1329 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-1 | Date/Time Prepared: 5/26/2023 12:48 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)	5,789	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	5,501	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	3,731	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	176	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	112	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)	11	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)	768	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)	9,134,828	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)	28,049	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)	310,379	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	8,824,449	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)	8,824,449	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)	1,604.15	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	17,646	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)	17,646	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1329 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-1 | Date/Time Prepared: 5/26/2023 12:48 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)	1,539,820	768	2,004.97	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	915,548	290	3,157.06	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	10,980	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)	28,626	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)	1,770	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,604.15	88.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-1329	Period: From 01/01/2022 To 12/31/2022	Worksheet D-1 Date/Time Prepared: 5/26/2023 12:48 pm
	Title XIX	Hospital	Cost

	Cost Center Description		
		1.00	
89.00	Observation bed cost (line 87 x line 88) (see instructions)	2,839,346	89.00

	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	1,118,062	9,134,828	0.122396	2,839,346	347,525	90.00
91.00	Nursing Program cost	0	9,134,828	0.000000	2,839,346	0	91.00
92.00	Allied health cost	0	9,134,828	0.000000	2,839,346	0	92.00
93.00	All other Medical Education	0	9,134,828	0.000000	2,839,346	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1329 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-3 | Date/Time Prepared: 5/26/2023 12:48 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		1,841,882		30.00
31.00	03100	INTENSIVE CARE UNIT		229,296		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.328317	486,886	159,853	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.161925	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.183535	460,503	84,518	54.00
60.00	06000	LABORATORY	0.145263	989,180	143,691	60.00
65.00	06500	RESPIRATORY THERAPY	0.613546	639,439	392,325	65.00
66.00	06600	PHYSICAL THERAPY	0.488121	78,089	38,117	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.602118	58,112	34,990	67.00
68.00	06800	SPEECH PATHOLOGY	0.594618	27,901	16,590	68.00
69.00	06900	ELECTROCARDIOLOGY	0.260233	111,181	28,933	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.299958	774,428	232,296	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.921021	298,893	275,287	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.360281	1,255,306	452,263	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	MEDICAL ARTS CENTER	0.000000		0	88.01
90.00	09000	CLINIC	0.570354	0	0	90.00
90.01	09001	WOUND CLINC	0.324563	0	0	90.01
90.02	09002	BEHAVIORAL HEALTH	0.000000	0	0	90.02
91.00	09100	EMERGENCY	0.410900	7,138	2,933	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.661024	17,120	11,317	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		5,204,176	1,873,113	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)		5,204,176		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-1329 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-3

Component CCN: 15-Z329 | Date/Time Prepared: 5/26/2023 12:48 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.328317	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.161925	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.183535	16,751	3,074	54.00
60.00	06000	LABORATORY	0.145263	35,243	5,120	60.00
65.00	06500	RESPIRATORY THERAPY	0.613546	26,408	16,203	65.00
66.00	06600	PHYSICAL THERAPY	0.488121	28,616	13,968	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.602118	20,622	12,417	67.00
68.00	06800	SPEECH PATHOLOGY	0.594618	3,598	2,139	68.00
69.00	06900	ELECTROCARDIOLOGY	0.260233	20,074	5,224	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.299958	23,859	7,157	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.921021	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.360281	50,946	18,355	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	MEDICAL ARTS CENTER	0.000000		0	88.01
90.00	09000	CLINIC	0.570354	0	0	90.00
90.01	09001	WOUND CLINC	0.324563	0	0	90.01
90.02	09002	BEHAVIORAL HEALTH	0.000000	0	0	90.02
91.00	09100	EMERGENCY	0.410900	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.661024	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		226,117	83,657	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)		226,117		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1329 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-3 | Date/Time Prepared: 5/26/2023 12:48 pm

Title XIX | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		3,328		30.00
31.00	03100	INTENSIVE CARE UNIT		453		31.00
43.00	04300	NURSERY		19,421		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.328317	301	99	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.161925	5,944	6,906	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.183535	1,118	205	54.00
60.00	06000	LABORATORY	0.145263	9,751	1,416	60.00
65.00	06500	RESPIRATORY THERAPY	0.613546	1,263	775	65.00
66.00	06600	PHYSICAL THERAPY	0.488121	30	15	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.602118	34	20	67.00
68.00	06800	SPEECH PATHOLOGY	0.594618	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.260233	167	43	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.299958	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.921021	49	45	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.360281	3,690	1,329	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	1.206282	0	0	88.00
88.01	08801	MEDICAL ARTS CENTER	1.388471	0	0	88.01
90.00	09000	CLINIC	0.570354	0	0	90.00
90.01	09001	WOUND CLINC	0.324563	0	0	90.01
90.02	09002	BEHAVIORAL HEALTH	0.000000	0	0	90.02
91.00	09100	EMERGENCY	0.410900	308	127	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.661024	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		22,655	10,980	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)		22,655		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-1329 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-3

Component CCN: 15-Z329 | Date/Time Prepared: 5/26/2023 12:48 pm

Title XIX | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.328317	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.161925	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.183535	0	0	54.00
60.00	06000	LABORATORY	0.145263	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.613546	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.488121	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.602118	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.594618	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.260233	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.299958	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.921021	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.360281	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	1.206282	0	0	88.00
88.01	08801	MEDICAL ARTS CENTER	1.388471	0	0	88.01
90.00	09000	CLINIC	0.570354	0	0	90.00
90.01	09001	WOUND CLINC	0.324563	0	0	90.01
90.02	09002	BEHAVIORAL HEALTH	0.000000	0	0	90.02
91.00	09100	EMERGENCY	0.410900	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.661024	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		0	0	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		0		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1329	Period: From 01/01/2022 To 12/31/2022	Worksheet E Part B Date/Time Prepared: 5/26/2023 12:48 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	17,294,953	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)	17,294,953	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)	17,467,903	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)	183,166	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	11,305,316	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	5,979,421	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	5,979,421	30.00
31.00	Primary payer payments	1,208	31.00
32.00	Subtotal (line 30 minus line 31)	5,978,213	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)	720,287	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	468,187	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	531,547	36.00
37.00	Subtotal (see instructions)	6,446,400	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)	6,446,400	40.00
40.01	Sequestration adjustment (see instructions)	81,225	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	8,255,312	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)	-1,890,137	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: 15-1329	Period: From 01/01/2022 To 12/31/2022	Worksheet E Part B Date/Time Prepared: 5/26/2023 12:48 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: 15-1329 | Period: From 01/01/2022 To 12/31/2022 | Worksheet E-1 Part I | Date/Time Prepared: 5/26/2023 12:48 pm

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		3,778,250		8,065,512	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	05/26/2022	189,800	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		189,800	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		3,778,250		8,255,312	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		197,262		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		1,890,137	6.02
7.00	Total Medicare program liability (see instructions)		3,975,512		6,365,175	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: 15-1329 | Component CCN: 15-Z329 | Period: From 01/01/2022 To 12/31/2022 | Worksheet E-1 Part I | Date/Time Prepared: 5/26/2023 12:48 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		332,962		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		332,962		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		23,577		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		356,539		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: 15-1329	Period: From 01/01/2022 To 12/31/2022	Worksheet E-1 Part II Date/Time Prepared: 5/26/2023 12:48 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: 15-1329 | Component CCN: 15-Z329 | Period: From 01/01/2022 To 12/31/2022 | Worksheet E-2 | Date/Time Prepared: 5/26/2023 12:48 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)	285,153	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)	84,494	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	176	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)	369,647	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	369,647	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)	369,647	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	8,558	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (see instructions)	361,089	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)	361,089	0	19.00
19.01	Sequestration adjustment (see instructions)	4,550	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	332,962	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)	23,577	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 - SWING BEDS | Provider CCN: 15-1329 | Component CCN: 15-Z329 | Period: From 01/01/2022 To 12/31/2022 | Worksheet E-2 | Date/Time Prepared: 5/26/2023 12:48 pm

Title XIX | 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)	0		1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)	0		2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swing-bed pass-through, see instructions)	0		3.00
3.01	Nursing and allied health payment-PARHM 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	0		5.00
6.00	Interns and residents not in approved teaching program (see instructions)	0		6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	0		8.00
9.00	Primary payer payments (see instructions)	0		9.00
10.00	Subtotal (line 8 minus line 9)	0		10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0		11.00
12.00	Subtotal (line 10 minus line 11)	0		12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	0		13.00
14.00	80% of Part B costs (line 12 x 80%)	0		14.00
15.00	Subtotal (see instructions)	0		15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0		16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			16.50
16.55	Rural community hospital demonstration project (§410A Demonstration) payment adjustment (see instructions)			16.55
16.99	Demonstration payment adjustment amount before sequestration	0		16.99
17.00	Allowable bad debts (see instructions)	0		17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0		17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0		18.00
19.00	Total (see instructions)	0		19.00
19.01	Sequestration adjustment (see instructions)	0		19.01
19.02	Demonstration payment adjustment amount after sequestration)	0		19.02
19.03	Sequestration adjustment-PARHM or CHART pass-throughs			19.03
19.25	Sequestration for non-claims based amounts (see instructions)	0		19.25
20.00	Interim payments	0		20.00
20.01	Interim payments-PARHM or CHART			20.01
21.00	Tentative settlement (for contractor use only)	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)	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		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: 15-1329	Period: From 01/01/2022 To 12/31/2022	Worksheet E-3 Part V Date/Time Prepared: 5/26/2023 12:48 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	4,381,743	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)	4,381,743	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	4,425,560	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)	4,425,560	19.00
20.00	Deductibles (exclude professional component)	424,356	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	4,001,204	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	4,001,204	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	38,522	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	25,039	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	28,819	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	4,026,243	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)	4,026,243	30.00
30.01	Sequestration adjustment (see instructions)	50,731	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	3,778,250	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)	197,262	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: 15-1329	Period: From 01/01/2022 To 12/31/2022	Worksheet E-3 Part VII Date/Time Prepared: 5/26/2023 12:48 pm
	Title XIX	Hospital	Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	28,626		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)	28,626	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	28,626	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	23,201		8.00
9.00	Ancillary service charges	22,655	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)	45,856	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)	45,856	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	17,230	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	28,626	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	28,626	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	28,626	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	28,626	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	28,626	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	28,626	0	40.00
41.00	Interim payments	34,733	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	-6,107	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: 15-1329 | Period: From 01/01/2022 To 12/31/2022 | Worksheet G | Date/Time Prepared: 5/26/2023 12:48 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	5,584,760	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	48,965,877	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-31,849,515	0	0	0	6.00
7.00	Inventory	1,513,421	0	0	0	7.00
8.00	Prepaid expenses	1,312,125	0	0	0	8.00
9.00	Other current assets	4,528,650	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	30,055,318	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	5,798,684	0	0	0	12.00
13.00	Land improvements	278,583	0	0	0	13.00
14.00	Accumulated depreciation	-259,590	0	0	0	14.00
15.00	Buildings	81,712,152	0	0	0	15.00
16.00	Accumulated depreciation	-54,379,994	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	7,615,900	0	0	0	19.00
20.00	Accumulated depreciation	-5,329,554	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	68,407,153	0	0	0	23.00
24.00	Accumulated depreciation	-53,087,385	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)	50,755,949	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	90,232,709	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	90,232,709	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	171,043,976	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	3,368,797	0	0	0	37.00
38.00	Salaries, wages, and fees payable	41,740	0	0	0	38.00
39.00	Payroll taxes payable	9,384,783	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	2,683,667	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	15,478,987	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	17,052,042	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	17,052,042	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	32,531,029	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	138,512,947				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)	138,512,947	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	171,043,976	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-1329 | Period: From 01/01/2022 To 12/31/2022 | Worksheet G-1 | Date/Time Prepared: 5/26/2023 12:48 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		148,560,142		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-10,047,195				2.00
3.00	Total (sum of line 1 and line 2)		138,512,947		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		138,512,947		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)		138,512,947		0		19.00

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 15-1329 | Period: From 01/01/2022 To 12/31/2022 | Worksheet G-2 Parts I & II Date/Time Prepared: 5/26/2023 12:48 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	5,935,474		5,935,474	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)	5,935,474		5,935,474	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	990,145		990,145	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	990,145		990,145	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	6,925,619		6,925,619	17.00
18.00	Ancillary services	19,159,645	187,741,391	206,901,036	18.00
19.00	Outpatient services	178,203	40,947,713	41,125,916	19.00
20.00	RURAL HEALTH CLINIC	0	2,221,071	2,221,071	20.00
20.01	MEDICAL ARTS CENTER	0	3,327,401	3,327,401	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				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE	0	1,772,515	1,772,515	26.00
27.00	OTHER PRO FEES	1,592,485	28,914,945	30,507,430	27.00
27.01	PRO FEES	1,004,259	16,575,807	17,580,066	27.01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	28,860,211	281,500,843	310,361,054	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		128,979,844		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)		128,979,844		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-1329 | Period: From 01/01/2022 To 12/31/2022 | Worksheet G-3 | Date/Time Prepared: 5/26/2023 12:48 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	310,361,054	1.00
2.00	Less contractual allowances and discounts on patients' accounts	185,842,382	2.00
3.00	Net patient revenues (line 1 minus line 2)	124,518,672	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	128,979,844	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-4,461,172	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER OPERATING INCOME	3,342,367	24.00
24.01	CONTRIBUTIONS	173,680	24.01
24.02	INVESTMENT RETURN	160,756	24.02
24.03	UNREALIZED GAIN, DERIVATIVE	-12,912,113	24.03
24.04	UNREALIZED GAIN, INVESTMENTS	843,544	24.04
24.05	TEMPORARILY RESTRICTED ASSETS	2,379	24.05
24.50	COVID-19 PHE Funding	2,803,364	24.50
25.00	Total other income (sum of lines 6-24)	-5,586,023	25.00
26.00	Total (line 5 plus line 25)	-10,047,195	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-10,047,195	29.00

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS

Provider CCN: 15-1329 | Hospice CCN: 15-1551 | Period: From 01/01/2022 To 12/31/2022 | Worksheet O | Date/Time Prepared: 5/26/2023 12:48 pm

Hospice I

		SALARIES	OTHER	SUBTOTAL (col. 1 plus col. 2)	RECLASSIFI-CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT*		0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP*		0	0	0	0	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	0	0	0	0	3.00
4.00	ADMINISTRATIVE & GENERAL*	186,488	174,400	360,888	0	360,888	4.00
5.00	PLANT OPERATION & MAINTENANCE*	0	0	0	0	0	5.00
6.00	LAUNDRY & LINEN SERVICE*	0	0	0	0	0	6.00
7.00	HOUSEKEEPING*	0	0	0	0	0	7.00
8.00	DIETARY*	0	0	0	0	0	8.00
9.00	NURSING ADMINISTRATION*	0	0	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES*	0	0	0	0	0	10.00
11.00	MEDICAL RECORDS*	0	0	0	0	0	11.00
12.00	STAFF TRANSPORTATION*	0	49,652	49,652	0	49,652	12.00
13.00	VOLUNTEER SERVICE COORDINATION*	0	0	0	0	0	13.00
14.00	PHARMACY*	0	92,287	92,287	0	92,287	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE*	0	0	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED**		0	0	0	0	25.00
26.00	PHYSICIAN SERVICES**	0	18,000	18,000	0	18,000	26.00
27.00	NURSE PRACTITIONER**	3,475	0	3,475	0	3,475	27.00
28.00	REGISTERED NURSE**	352,060	0	352,060	0	352,060	28.00
29.00	LPN/LVN**	0	0	0	0	0	29.00
30.00	PHYSICAL THERAPY**	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY**	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES**	63,275	0	63,275	0	63,275	33.00
34.00	SPIRITUAL COUNSELING**	22,434	0	22,434	0	22,434	34.00
35.00	DIETARY COUNSELING**	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER**	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES**	57,970	0	57,970	0	57,970	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION**	0	0	0	0	0	39.00
40.00	IMAGING SERVICES**	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS**	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE**	0	0	0	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS**	0	0	0	0	0	42.50
43.00	OUTPATIENT SERVICES**	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY**	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY**	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	0	0	0	0	46.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM *	0	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM *	0	0	0	0	0	61.00
62.00	FUNDRAISING*	0	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM*	0	0	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES*	0	0	0	0	0	65.00
66.00	RESIDENTIAL CARE*	0	0	0	0	0	66.00
67.00	ADVERTISING*	0	0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING*	0	0	0	0	0	68.00
69.00	THRIFT STORE*	0	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD*	0	0	0	0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)*	0	0	0	0	0	71.00
100.00	TOTAL	685,702	334,339	1,020,041	0	1,020,041	100.00

* Transfer the amounts in column 7 to Wkst. O-5, column 1, line as appropriate.
** See instructions. Do not transfer the amounts in column 7 to Wkst. O-5.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS

Provider CCN: 15-1329 | Hospice CCN: 15-1551 | Period: From 01/01/2022 To 12/31/2022 | Worksheet O | Date/Time Prepared: 5/26/2023 12:48 pm

Hospice I

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)		
		6.00	7.00		
	GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT*	0	0		1.00
2.00	CAP REL COSTS-MVBLE EQUIP*	0	0		2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	0		3.00
4.00	ADMINISTRATIVE & GENERAL*	0	360,888		4.00
5.00	PLANT OPERATION & MAINTENANCE*	0	0		5.00
6.00	LAUNDRY & LINEN SERVICE*	0	0		6.00
7.00	HOUSEKEEPING*	0	0		7.00
8.00	DIETARY*	0	0		8.00
9.00	NURSING ADMINISTRATION*	0	0		9.00
10.00	ROUTINE MEDICAL SUPPLIES*	0	0		10.00
11.00	MEDICAL RECORDS*	0	0		11.00
12.00	STAFF TRANSPORTATION*	0	49,652		12.00
13.00	VOLUNTEER SERVICE COORDINATION*	0	0		13.00
14.00	PHARMACY*	0	92,287		14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0		15.00
16.00	OTHER GENERAL SERVICE*	0	0		16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES				17.00
	DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED**	0	0		25.00
26.00	PHYSICIAN SERVICES**	0	18,000		26.00
27.00	NURSE PRACTITIONER**	0	3,475		27.00
28.00	REGISTERED NURSE**	0	352,060		28.00
29.00	LPN/LVN**	0	0		29.00
30.00	PHYSICAL THERAPY**	0	0		30.00
31.00	OCCUPATIONAL THERAPY**	0	0		31.00
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	0		32.00
33.00	MEDICAL SOCIAL SERVICES**	0	63,275		33.00
34.00	SPIRITUAL COUNSELING**	0	22,434		34.00
35.00	DIETARY COUNSELING**	0	0		35.00
36.00	COUNSELING - OTHER**	0	0		36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES**	0	57,970		37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	0		38.00
39.00	PATIENT TRANSPORTATION**	0	0		39.00
40.00	IMAGING SERVICES**	0	0		40.00
41.00	LABS & DIAGNOSTICS**	0	0		41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE**	0	0		42.00
42.50	DRUGS CHARGED TO PATIENTS**	0	0		42.50
43.00	OUTPATIENT SERVICES**	0	0		43.00
44.00	PALLIATIVE RADIATION THERAPY**	0	0		44.00
45.00	PALLIATIVE CHEMOTHERAPY**	0	0		45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	0		46.00
	NONREIMBURSABLE COST CENTERS				
60.00	BEREAVEMENT PROGRAM *	0	0		60.00
61.00	VOLUNTEER PROGRAM *	0	0		61.00
62.00	FUNDRAISING*	0	0		62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0		63.00
64.00	PALLIATIVE CARE PROGRAM*	0	0		64.00
65.00	OTHER PHYSICIAN SERVICES*	0	0		65.00
66.00	RESIDENTIAL CARE*	0	0		66.00
67.00	ADVERTISING*	0	0		67.00
68.00	TELEHEALTH/TELEMONITORING*	0	0		68.00
69.00	THRIFT STORE*	0	0		69.00
70.00	NURSING FACILITY ROOM & BOARD*	0	0		70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)*	0	0		71.00
100.00	TOTAL	0	1,020,041		100.00

* Transfer the amounts in column 7 to Wkst. O-5, column 1, line as appropriate.
** See instructions. Do not transfer the amounts in column 7 to Wkst. O-5.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPICE ROUTINE HOME CARE

Provider CCN: 15-1329 Hospice CCN: 15-1551 | Period: From 01/01/2022 To 12/31/2022 | Worksheet O-2 | Date/Time Prepared: 5/26/2023 12:48 pm

Hospice I

		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI-CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED						25.00
26.00	PHYSICIAN SERVICES	0	18,000	18,000	0	18,000	26.00
27.00	NURSE PRACTITIONER	3,472	0	3,472	0	3,472	27.00
28.00	REGISTERED NURSE	351,716	0	351,716	0	351,716	28.00
29.00	LPN/LVN	0	0	0	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	63,213	0	63,213	0	63,213	33.00
34.00	SPIRITUAL COUNSELING	22,412	0	22,412	0	22,412	34.00
35.00	DIETARY COUNSELING	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	57,913	0	57,913	0	57,913	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	0	0	0	39.00
40.00	IMAGING SERVICES	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	0	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	0	46.00
100.00	TOTAL *	498,726	18,000	516,726	0	516,726	100.00

* Transfer the amount in column 7 to Wkst. O-5, column 1, line 51.

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)		
		6.00	7.00		
	DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED				25.00
26.00	PHYSICIAN SERVICES	0	18,000		26.00
27.00	NURSE PRACTITIONER	0	3,472		27.00
28.00	REGISTERED NURSE	0	351,716		28.00
29.00	LPN/LVN	0	0		29.00
30.00	PHYSICAL THERAPY	0	0		30.00
31.00	OCCUPATIONAL THERAPY	0	0		31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0		32.00
33.00	MEDICAL SOCIAL SERVICES	0	63,213		33.00
34.00	SPIRITUAL COUNSELING	0	22,412		34.00
35.00	DIETARY COUNSELING	0	0		35.00
36.00	COUNSELING - OTHER	0	0		36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	57,913		37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0		38.00
39.00	PATIENT TRANSPORTATION	0	0		39.00
40.00	IMAGING SERVICES	0	0		40.00
41.00	LABS & DIAGNOSTICS	0	0		41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0		42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0		42.50
43.00	OUTPATIENT SERVICES	0	0		43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0		44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0		45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0		46.00
100.00	TOTAL *	0	516,726		100.00

* Transfer the amount in column 7 to Wkst. O-5, column 1, line 51.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPICE INPATIENT RESPITE CARE

Provider CCN: 15-1329 | Hospice CCN: 15-1551 | Period: From 01/01/2022 To 12/31/2022 | Worksheet O-3 | Date/Time Prepared: 5/26/2023 12:48 pm

Hospice I

		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI-CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED		0	0	0	0	25.00
26.00	PHYSICIAN SERVICES	0	0	0	0	0	26.00
27.00	NURSE PRACTITIONER	3	0	3	0	3	27.00
28.00	REGISTERED NURSE	344	0	344	0	344	28.00
29.00	LPN/LVN	0	0	0	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	62	0	62	0	62	33.00
34.00	SPIRITUAL COUNSELING	22	0	22	0	22	34.00
35.00	DIETARY COUNSELING	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	57	0	57	0	57	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	0	0	0	39.00
40.00	IMAGING SERVICES	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	0	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	0	46.00
100.00	TOTAL *	488	0	488	0	488	100.00

* Transfer the amount in column 7 to Wkst. O-5, column 1, line 52.

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)		
		6.00	7.00		
	DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED	0	0		25.00
26.00	PHYSICIAN SERVICES	0	0		26.00
27.00	NURSE PRACTITIONER	0	3		27.00
28.00	REGISTERED NURSE	0	344		28.00
29.00	LPN/LVN	0	0		29.00
30.00	PHYSICAL THERAPY	0	0		30.00
31.00	OCCUPATIONAL THERAPY	0	0		31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0		32.00
33.00	MEDICAL SOCIAL SERVICES	0	62		33.00
34.00	SPIRITUAL COUNSELING	0	22		34.00
35.00	DIETARY COUNSELING	0	0		35.00
36.00	COUNSELING - OTHER	0	0		36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	57		37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0		38.00
39.00	PATIENT TRANSPORTATION	0	0		39.00
40.00	IMAGING SERVICES	0	0		40.00
41.00	LABS & DIAGNOSTICS	0	0		41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0		42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0		42.50
43.00	OUTPATIENT SERVICES	0	0		43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0		44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0		45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0		46.00
100.00	TOTAL *	0	488		100.00

* Transfer the amount in column 7 to Wkst. O-5, column 1, line 52.

COST ALLOCATION - DETERMINATION OF HOSPITAL-BASED HOSPICE NET EXPENSES FOR ALLOCATION

Provider CCN: 15-1329 Hospice CCN: 15-1551

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

Worksheet O-5

Date/Time Prepared: 5/26/2023 12:48 pm

Hospice I

	Descriptions	HOSPICE DIRECT EXPENSES (see instructions)	GENERAL SERVICE EXPENSES FROM WKST B PART I (see instructions)	TOTAL EXPENSES (sum of cols. 1 + 2)	
		1.00	2.00	3.00	
	GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT	0	2,596	2,596	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	5,147	5,147	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	244,791	244,791	3.00
4.00	ADMINISTRATIVE & GENERAL	360,888	240,569	601,457	4.00
5.00	PLANT OPERATION & MAINTENANCE	0	6,929	6,929	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	6.00
7.00	HOUSEKEEPING	0	3,616	3,616	7.00
8.00	DIETARY	0	0	0	8.00
9.00	NURSING ADMINISTRATION	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0	0	10.00
11.00	MEDICAL RECORDS	0	0	0	11.00
12.00	STAFF TRANSPORTATION	49,652		49,652	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0		0	13.00
14.00	PHARMACY	92,287	0	92,287	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0		0	15.00
16.00	OTHER GENERAL SERVICE	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES		0	0	17.00
	LEVEL OF CARE				
50.00	HOSPICE CONTINUOUS HOME CARE	0		0	50.00
51.00	HOSPICE ROUTINE HOME CARE	516,726		516,726	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	488		488	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0		0	53.00
	NONREIMBURSABLE COST CENTERS				
60.00	BEREAVEMENT PROGRAM	0		0	60.00
61.00	VOLUNTEER PROGRAM	0		0	61.00
62.00	FUNDRAISING	0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0	63.00
64.00	PALLIATIVE CARE PROGRAM	0		0	64.00
65.00	OTHER PHYSICIAN SERVICES	0		0	65.00
66.00	RESIDENTIAL CARE	0		0	66.00
67.00	ADVERTISING	0		0	67.00
68.00	TELEHEALTH/TELEMONITORING	0		0	68.00
69.00	THRIFT STORE	0		0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0		0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0		0	71.00
99.00	NEGATIVE COST CENTER	0		0	99.00
100.00	TOTAL	1,020,041	503,648	1,523,689	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS | Provider CCN: 15-1329 | Hospice CCN: 15-1551 | Period: From 01/01/2022 To 12/31/2022 | Worksheet O-6 Part I | Date/Time Prepared: 5/26/2023 12:48 pm

Hospice I

	Descriptions	TOTAL EXPENSES	CAP REL BLDG & FIX	CAP REL MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL	
		0	1.00	2.00	3.00	3A	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	2,596	2,596				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	5,147		5,147			2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	244,791	0	0	244,791		3.00
4.00	ADMINISTRATIVE & GENERAL	601,457	2,596	5,147	0	609,200	4.00
5.00	PLANT OPERATION & MAINTENANCE	6,929	0	0	0	6,929	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	0	0	6.00
7.00	HOUSEKEEPING	3,616	0	0	0	3,616	7.00
8.00	DIETARY	0	0	0	0	0	8.00
9.00	NURSING ADMINISTRATION	0	0	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0	0	0	0	10.00
11.00	MEDICAL RECORDS	0	0	0	0	0	11.00
12.00	STAFF TRANSPORTATION	49,652	0	0	0	49,652	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0	0	0	0	13.00
14.00	PHARMACY	92,287	0	0	0	92,287	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE	0	0	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES		0	0		0	17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0			0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	516,726			244,551	761,277	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	488	0	0	240	728	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0	0	0	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM	0	0	0	0	0	61.00
62.00	FUNDRAISING	0	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0	0	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0	0	0	0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0	0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0	0	0	0	0	68.00
69.00	THRIFT STORE	0	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0				0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0		99.00
100.00	TOTAL	1,523,689	2,596	5,147	244,791	1,523,689	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS | Provider CCN: 15-1329 Hospice CCN: 15-1551 | Period: From 01/01/2022 To 12/31/2022 | Worksheet O-6 Part I Date/Time Prepared: 5/26/2023 12:48 pm

Hospice I

	Descriptions	ADMINISTRATIVE & GENERAL	PLANT OPERATION & MAINTENANCE	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		4.00	5.00	6.00	7.00	8.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL	609,200					4.00
5.00	PLANT OPERATION & MAINTENANCE	4,616	11,545				5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0			6.00
7.00	HOUSEKEEPING	2,409	0		6,025		7.00
8.00	DIETARY	0	0		0	0	8.00
9.00	NURSING ADMINISTRATION	0	0		0		9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0		0		10.00
11.00	MEDICAL RECORDS	0	0		0		11.00
12.00	STAFF TRANSPORTATION	33,076	0		0		12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0		0		13.00
14.00	PHARMACY	61,478	0		0		14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0		0		15.00
16.00	OTHER GENERAL SERVICE	0	0		0		16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0		0		17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0					50.00
51.00	HOSPICE ROUTINE HOME CARE	507,136					51.00
52.00	HOSPICE INPATIENT RESPITE CARE	485	11,545	0	6,025	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0	0	0	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0	0		0		60.00
61.00	VOLUNTEER PROGRAM	0	0		0		61.00
62.00	FUNDRAISING	0	0		0		62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0		0		63.00
64.00	PALLIATIVE CARE PROGRAM	0	0		0		64.00
65.00	OTHER PHYSICIAN SERVICES	0	0		0		65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0	0		0		67.00
68.00	TELEHEALTH/TELEMONITORING	0	0		0		68.00
69.00	THRIFT STORE	0	0		0		69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0	99.00
100.00	TOTAL	609,200	11,545	0	6,025	0	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS | Provider CCN: 15-1329 Hospice CCN: 15-1551 | Period: From 01/01/2022 To 12/31/2022 | Worksheet O-6 Part I Date/Time Prepared: 5/26/2023 12:48 pm

Hospice I

	Descriptions	NURSING ADMINISTRATION	ROUTINE MEDICAL SUPPLIES	MEDICAL RECORDS	STAFF TRANSPORTATION	VOLUNTEER SERVICE COORDINATION	
		9.00	10.00	11.00	12.00	13.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION	0					9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0				10.00
11.00	MEDICAL RECORDS	0		0			11.00
12.00	STAFF TRANSPORTATION	0			82,728		12.00
13.00	VOLUNTEER SERVICE COORDINATION	0			0	0	13.00
14.00	PHARMACY	0			0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0			0	0	15.00
16.00	OTHER GENERAL SERVICE	0			0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	0	0	0	82,647	0	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	0	81	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0	0	0	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0			0	0	60.00
61.00	VOLUNTEER PROGRAM	0			0	0	61.00
62.00	FUNDRAISING	0			0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0			0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0			0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0			0	0	65.00
66.00	RESIDENTIAL CARE	0			0	0	66.00
67.00	ADVERTISING	0			0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0			0	0	68.00
69.00	THRIFT STORE	0			0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0			0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0	99.00
100.00	TOTAL	0	0	0	82,728	0	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS | Provider CCN: 15-1329 | Hospice CCN: 15-1551 | Period: From 01/01/2022 To 12/31/2022 | Worksheet O-6 Part I | Date/Time Prepared: 5/26/2023 12:48 pm

Hospice I

	Descriptions	PHARMACY	PHYSICIAN ADMINISTRATIVE SERVICES	OTHER GENERAL SERVICE	PATIENT/ RESIDENTIAL CARE SERVICES	TOTAL	
		14.00	15.00	16.00	17.00	18.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION						9.00
10.00	ROUTINE MEDICAL SUPPLIES						10.00
11.00	MEDICAL RECORDS						11.00
12.00	STAFF TRANSPORTATION						12.00
13.00	VOLUNTEER SERVICE COORDINATION						13.00
14.00	PHARMACY	153,765					14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0				15.00
16.00	OTHER GENERAL SERVICE	0		0			16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES				0		17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0		0	50.00
51.00	HOSPICE ROUTINE HOME CARE	153,614	0	0		1,504,674	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	151	0	0	0	19,015	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0	0	0	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0		0		0	60.00
61.00	VOLUNTEER PROGRAM	0		0		0	61.00
62.00	FUNDRAISING	0		0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0		0	63.00
64.00	PALLIATIVE CARE PROGRAM	0		0		0	64.00
65.00	OTHER PHYSICIAN SERVICES	0		0		0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0		0		0	67.00
68.00	TELEHEALTH/TELEMONITORING	0		0		0	68.00
69.00	THRIFT STORE	0		0		0	69.00
70.00	NURSING FACILITY ROOM & BOARD					0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0	99.00
100.00	TOTAL	153,765	0	0	0	1,523,689	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS
STATISTICAL BASIS

Provider CCN: 15-1329
Hospice CCN: 15-1551

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

Worksheet O-6
Part II
Date/Time Prepared:
5/26/2023 12:48 pm

Hospice I

	Cost Center Descriptions	CAP REL BLDG & FIX (SQUARE FEET)	CAP REL MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	RECONCILIATION	ADMINISTRATIVE & GENERAL (ACCUMULATED COSTS)	
		1.00	2.00	3.00	4A	4.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	2,374					1.00
2.00	CAP REL COSTS-MVBLE EQUIP		5,026				2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	242,110			3.00
4.00	ADMINISTRATIVE & GENERAL	2,374	5,026	0	-609,200	914,489	4.00
5.00	PLANT OPERATION & MAINTENANCE	0	0	0	0	6,929	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	0	0	6.00
7.00	HOUSEKEEPING	0	0	0	0	3,616	7.00
8.00	DIETARY	0	0	0	0	0	8.00
9.00	NURSING ADMINISTRATION	0	0	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0	0	0	0	10.00
11.00	MEDICAL RECORDS	0	0	0	0	0	11.00
12.00	STAFF TRANSPORTATION	0	0	0	0	49,652	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0	0	0	0	13.00
14.00	PHARMACY	0	0	0	0	92,287	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE	0	0	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0		0	0	17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE			0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE			241,873	0	761,277	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	237	0	728	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0	0	0	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM	0	0	0	0	0	61.00
62.00	FUNDRAISING	0	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0	0	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0	0	0	0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0	0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0	0	0	0	0	68.00
69.00	THRIFT STORE	0	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD				0		70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. O-6, Part I)	2,596	5,147	244,791		609,200	100.00
101.00	UNIT COST MULTIPLIER	1.093513	1.024075	1.011073		0.666164	101.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS
STATISTICAL BASIS

Provider CCN: 15-1329
Hospice CCN: 15-1551

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

Worksheet O-6
Part II
Date/Time Prepared:
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Hospice I

	Cost Center Descriptions	PLANT OPERATION & MAINTENANCE (SQUARE FEET)	LAUNDRY & LINEN SERVICE (IN-FACILITY DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (IN-FACILITY DAYS)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	
		5.00	6.00	7.00	8.00	9.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE	12,752					5.00
6.00	LAUNDRY & LINEN SERVICE	0	0				6.00
7.00	HOUSEKEEPING	0		6,867			7.00
8.00	DIETARY	0		0	0		8.00
9.00	NURSING ADMINISTRATION	0		0		0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0		0		0	10.00
11.00	MEDICAL RECORDS	0		0		0	11.00
12.00	STAFF TRANSPORTATION	0		0		0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0		0		0	13.00
14.00	PHARMACY	0		0		0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0		0		0	15.00
16.00	OTHER GENERAL SERVICE	0		0		0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0		0			17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE					0	50.00
51.00	HOSPICE ROUTINE HOME CARE					0	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	12,752	0	6,867	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0	0	0	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0		0		0	60.00
61.00	VOLUNTEER PROGRAM	0		0		0	61.00
62.00	FUNDRAISING	0		0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0		0	63.00
64.00	PALLIATIVE CARE PROGRAM	0		0		0	64.00
65.00	OTHER PHYSICIAN SERVICES	0		0		0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0		0		0	67.00
68.00	TELEHEALTH/TELEMONITORING	0		0		0	68.00
69.00	THRIFT STORE	0		0		0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. O-6, Part I)	11,545	0	6,025	0	0	100.00
101.00	UNIT COST MULTIPLIER	0.905348	0.000000	0.877385	0.000000	0.000000	101.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS
STATISTICAL BASIS

Provider CCN: 15-1329
Hospice CCN: 15-1551

Period:
From 01/01/2022
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Part II
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Hospice I

	Cost Center Descriptions	ROUTINE MEDICAL SUPPLIES (PATIENT DAYS)	MEDICAL RECORDS (PATIENT DAYS)	STAFF TRANSPORTATION (MILEAGE)	VOLUNTEER SERVICE COORDINATION (HOURS OF SERVICE)	PHARMACY (CHARGES)	
		10.00	11.00	12.00	13.00	14.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION						9.00
10.00	ROUTINE MEDICAL SUPPLIES	0					10.00
11.00	MEDICAL RECORDS		0				11.00
12.00	STAFF TRANSPORTATION			90,004			12.00
13.00	VOLUNTEER SERVICE COORDINATION			0	0		13.00
14.00	PHARMACY			0	0	167,288	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES			0	0	0	15.00
16.00	OTHER GENERAL SERVICE			0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	0	0	89,916	0	167,124	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	88	0	164	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0	0	0	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM			0	0	0	60.00
61.00	VOLUNTEER PROGRAM			0	0	0	61.00
62.00	FUNDRAISING			0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS			0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM			0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES			0	0	0	65.00
66.00	RESIDENTIAL CARE			0	0	0	66.00
67.00	ADVERTISING			0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING			0	0	0	68.00
69.00	THRIFT STORE			0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)			0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. O-6, Part I)	0	0	82,728	0	153,765	100.00
101.00	UNIT COST MULTIPLIER	0.000000	0.000000	0.919159	0.000000	0.919163	101.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS
STATISTICAL BASIS

Provider CCN: 15-1329
Hospice CCN: 15-1551

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

Worksheet O-6
Part II
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Hospice I

	Cost Center Descriptions	PHYSICIAN ADMINISTRATIVE SERVICES (PATIENT DAYS)	OTHER GENERAL SERVICE (SPECIFY BASIS)	PATIENT/ RESIDENTIAL CARE SERVICES (IN-FACILITY DAYS)		
		15.00	16.00	17.00		
	GENERAL SERVICE COST CENTERS					
1.00	CAP REL COSTS-BLDG & FIXT					1.00
2.00	CAP REL COSTS-MVBLE EQUIP					2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT					3.00
4.00	ADMINISTRATIVE & GENERAL					4.00
5.00	PLANT OPERATION & MAINTENANCE					5.00
6.00	LAUNDRY & LINEN SERVICE					6.00
7.00	HOUSEKEEPING					7.00
8.00	DIETARY					8.00
9.00	NURSING ADMINISTRATION					9.00
10.00	ROUTINE MEDICAL SUPPLIES					10.00
11.00	MEDICAL RECORDS					11.00
12.00	STAFF TRANSPORTATION					12.00
13.00	VOLUNTEER SERVICE COORDINATION					13.00
14.00	PHARMACY					14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0				15.00
16.00	OTHER GENERAL SERVICE		0			16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES			0		17.00
	LEVEL OF CARE					
50.00	HOSPICE CONTINUOUS HOME CARE	0	0			50.00
51.00	HOSPICE ROUTINE HOME CARE	0	0			51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	0		52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0		53.00
	NONREIMBURSABLE COST CENTERS					
60.00	BEREAVEMENT PROGRAM		0			60.00
61.00	VOLUNTEER PROGRAM		0			61.00
62.00	FUNDRAISING		0			62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS		0			63.00
64.00	PALLIATIVE CARE PROGRAM		0			64.00
65.00	OTHER PHYSICIAN SERVICES		0			65.00
66.00	RESIDENTIAL CARE	0	0	0		66.00
67.00	ADVERTISING		0			67.00
68.00	TELEHEALTH/TELEMONITORING		0			68.00
69.00	THRIFT STORE		0			69.00
70.00	NURSING FACILITY ROOM & BOARD					70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0		71.00
99.00	NEGATIVE COST CENTER					99.00
100.00	COST TO BE ALLOCATED (per Wkst. O-6, Part I)	0	0	0		100.00
101.00	UNIT COST MULTIPLIER	0.000000	0.000000	0.000000		101.00

APPORTIONMENT OF HOSPITAL-BASED HOSPICE SHARED SERVICE COSTS BY LEVEL OF CARE

Provider CCN: 15-1329 Hospice CCN: 15-1551

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

Worksheet O-7

Date/Time Prepared: 5/26/2023 12:48 pm

Hospice I

	Cost Center Descriptions	From Wkst. C, Part I, Col. 9 line	Cost to Charge Ratio	Charges by LOC (from Provider Records) HCHC	HRHC	HIRC	
		0	1.00	2.00	3.00	4.00	
	ANCILLARY SERVICE COST CENTERS						
1.00	PHYSICAL THERAPY	66.00	0.488121	0	0	0	1.00
2.00	OCCUPATIONAL THERAPY	67.00	0.602118	0	0	0	2.00
3.00	SPEECH PATHOLOGY	68.00	0.594618	0	0	0	3.00
4.00	DRUGS CHARGED TO PATIENTS	73.00	0.360281	0	0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00					5.00
6.00	LABORATORY	60.00	0.145263	0	0	0	6.00
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0.299958	0	0	0	7.00
8.00	OTHER OUTPATIENT SERVICE COST CENTER	93.00					8.00
9.00	RADIOLOGY-THERAPEUTIC	55.00					9.00
10.00	OTHER ANCILLARY SERVICE COST CENTERS	76.00					10.00
11.00	Totals (sum of lines 1-11)						11.00

	Cost Center Descriptions	Charges by LOC (from Provider Records) HGIP	Shared Service Costs by LOC HCHC (col. 1 x col. 2)	HRHC (col. 1 x col. 3)	HIRC (col. 1 x col. 4)	HGIP (col. 1 x col. 5)	
		5.00	6.00	7.00	8.00	9.00	
	ANCILLARY SERVICE COST CENTERS						
1.00	PHYSICAL THERAPY	0	0	0	0	0	1.00
2.00	OCCUPATIONAL THERAPY	0	0	0	0	0	2.00
3.00	SPEECH PATHOLOGY	0	0	0	0	0	3.00
4.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED						5.00
6.00	LABORATORY	0	0	0	0	0	6.00
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	7.00
8.00	OTHER OUTPATIENT SERVICE COST CENTER						8.00
9.00	RADIOLOGY-THERAPEUTIC						9.00
10.00	OTHER ANCILLARY SERVICE COST CENTERS						10.00
11.00	Totals (sum of lines 1-11)		0	0	0	0	11.00

CALCULATION OF HOSPITAL-BASED HOSPICE PER DIEM COST

Provider CCN: 15-1329 | Hospice CCN: 15-1551 | Period: From 01/01/2022 To 12/31/2022 | Worksheet O-8 | Date/Time Prepared: 5/26/2023 12:48 pm

Hospice I

		TITLE XVIII MEDICARE	TITLE XIX MEDICAID	TOTAL	
		1.00	2.00	3.00	
	HOSPICE CONTINUOUS HOME CARE				
1.00	Total cost (Wkst. O-6, Part I, col. 18, line 50 plus Wkst. O-7, col. 6, line 11)			0	1.00
2.00	Total unduplicated days (Wkst. S-9, col. 4, line 10)			0	2.00
3.00	Total average cost per diem (line 1 divided by line 2)			0.00	3.00
4.00	Unduplicated program days (Wkst. S-9 col. as appropriate, line 10)	0	0		4.00
5.00	Program cost (line 3 times line 4)	0	0		5.00
	HOSPICE ROUTINE HOME CARE				
6.00	Total cost (Wkst. O-6, Part I, col. 18, line 51 plus Wkst. O-7, col. 7, line 11)			1,504,674	6.00
7.00	Total unduplicated days (Wkst. S-9, col. 4, line 11)			10,213	7.00
8.00	Total average cost per diem (line 6 divided by line 7)			147.33	8.00
9.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 11)	9,567	10		9.00
10.00	Program cost (line 8 times line 9)	1,409,506	1,473		10.00
	HOSPICE INPATIENT RESPITE CARE				
11.00	Total cost (Wkst. O-6, Part I, col. 18, line 52 plus Wkst. O-7, col. 8, line 11)			19,015	11.00
12.00	Total unduplicated days (Wkst. S-9, col. 4, line 12)			10	12.00
13.00	Total average cost per diem (line 11 divided by line 12)			1,901.50	13.00
14.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 12)	10	0		14.00
15.00	Program cost (line 13 times line 14)	19,015	0		15.00
	HOSPICE GENERAL INPATIENT CARE				
16.00	Total cost (Wkst. O-6, Part I, col. 18, line 53 plus Wkst. O-7, col. 9, line 11)			0	16.00
17.00	Total unduplicated days (Wkst. S-9, col. 4, line 13)			0	17.00
18.00	Total average cost per diem (line 16 divided by line 17)			0.00	18.00
19.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 13)	0	0		19.00
20.00	Program cost (line 18 times line 19)	0	0		20.00
	TOTAL HOSPICE CARE				
21.00	Total cost (sum of line 1 + line 6 + line 11 + line 16)			1,523,689	21.00
22.00	Total unduplicated days (Wkst. S-9, col. 4, line 14)			10,223	22.00
23.00	Average cost per diem (line 21 divided by line 22)			149.05	23.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1329 | Component CCN: 15-8511 | Period: From 01/01/2022 To 12/31/2022 | Worksheet M-1 | Date/Time Prepared: 5/26/2023 12:48 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	142,801	501	143,302	0	143,302	1.00
2.00	Physician Assistant	32,015	0	32,015	0	32,015	2.00
3.00	Nurse Practitioner	430,473	0	430,473	0	430,473	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	137,419	0	137,419	0	137,419	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	399,544	0	399,544	0	399,544	9.00
10.00	Subtotal (sum of lines 1 through 9)	1,142,252	501	1,142,753	0	1,142,753	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	130,790	130,790	0	130,790	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	130,790	130,790	0	130,790	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,142,252	131,291	1,273,543	0	1,273,543	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	53,952	53,952	0	53,952	29.00
30.00	Administrative Costs	302,082	9,919	312,001	0	312,001	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	302,082	63,871	365,953	0	365,953	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,444,334	195,162	1,639,496	0	1,639,496	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS | Provider CCN: 15-1329 | Component CCN: 15-8511 | Period: From 01/01/2022 To 12/31/2022 | Worksheet M-1 | Date/Time Prepared: 5/26/2023 12:48 pm

RHC I | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	143,302		1.00
2.00	Physician Assistant	0	32,015		2.00
3.00	Nurse Practitioner	0	430,473		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	137,419		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	399,544		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	1,142,753		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	130,790		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	130,790		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	1,273,543		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	53,952		29.00
30.00	Administrative Costs	0	312,001		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	365,953		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	1,639,496		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1329 | Component CCN: 15-8567 | Period: From 01/01/2022 To 12/31/2022 | Worksheet M-1 | Date/Time Prepared: 5/26/2023 12:48 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	1,013,235	0	1,013,235	-422,215	591,020	1.00
2.00	Physician Assistant	2,865	0	2,865	-1,194	1,671	2.00
3.00	Nurse Practitioner	113,501	0	113,501	-47,296	66,205	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	297,418	0	297,418	-123,934	173,484	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	701,958	0	701,958	-292,506	409,452	9.00
10.00	Subtotal (sum of lines 1 through 9)	2,128,977	0	2,128,977	-887,145	1,241,832	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	104,634	104,634	-43,601	61,033	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	104,634	104,634	-43,601	61,033	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	2,128,977	104,634	2,233,611	-930,746	1,302,865	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	63,683	63,683	-26,537	37,146	29.00
30.00	Administrative Costs	435,380	28,256	463,636	-193,197	270,439	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	435,380	91,939	527,319	-219,734	307,585	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	2,564,357	196,573	2,760,930	-1,150,480	1,610,450	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS | Provider CCN: 15-1329 | Component CCN: 15-8567 | Period: From 01/01/2022 To 12/31/2022 | Worksheet M-1 | Date/Time Prepared: 5/26/2023 12:48 pm

RHC II | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	591,020		1.00
2.00	Physician Assistant	0	1,671		2.00
3.00	Nurse Practitioner	0	66,205		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	173,484		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	409,452		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	1,241,832		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	61,033		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	61,033		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	1,302,865		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	37,146		29.00
30.00	Administrative Costs	0	270,439		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	307,585		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	1,610,450		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-1329 | Component CCN: 15-8511 | Period: From 01/01/2022 To 12/31/2022 | Worksheet M-2 | Date/Time Prepared: 5/26/2023 12:48 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	0.53	1,818	1	1		1.00
2.00	Physician Assistant	0.20	321	1	0		2.00
3.00	Nurse Practitioner	2.64	9,300	1	3		3.00
4.00	Subtotal (sum of lines 1 through 3)	3.37	11,439		4	11,439	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	3.37	11,439			11,439	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					1,273,543	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					1,273,543	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)					365,953	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					1,039,741	15.00
16.00	Total overhead (sum of lines 14 and 15)					1,405,694	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					1,405,694	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					1,405,694	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					2,679,237	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-1329 | Component CCN: 15-8567 | Period: From 01/01/2022 To 12/31/2022 | Worksheet M-2 | Date/Time Prepared: 5/26/2023 12:48 pm

RHC II | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	1.96	8,918	4,200	8,232		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	0.38	771	2,100	798		3.00
4.00	Subtotal (sum of lines 1 through 3)	2.34	9,689		9,030	9,689	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	2.34	9,689			9,689	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					1,302,865	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					1,302,865	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)					307,585	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					1,084,396	15.00
16.00	Total overhead (sum of lines 14 and 15)					1,391,981	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					1,391,981	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					1,391,981	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					2,694,846	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 15-1329 Component CCN: 15-8511	Period: From 01/01/2022 To 12/31/2022	Worksheet M-3 Date/Time Prepared: 5/26/2023 12:48 pm
	Title XVIII	RHC I	Cost

		1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES		
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)	2,679,237	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)	16,451	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)	2,662,786	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)	11,439	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)	11,439	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)	232.78	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	255.79	8.00
9.00	Rate for Program covered visits (see instructions)	0.00	232.78	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	1,602	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	372,914	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	27	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	6,285	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	6,285	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	379,199	16.00
16.01	Total program charges (see instructions)(from contractor's records)		312,370	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		27,361	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		33,215	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.)		249,358	16.04
16.05	Total program cost (see instructions)	0	282,573	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		34,287	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		50,146	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		282,573	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		5,180	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		287,753	22.00
23.00	Allowable bad debts (see instructions)		2,481	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		1,613	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		307	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)		289,366	26.00
26.01	Sequestration adjustment (see instructions)		3,646	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		303,763	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)		-18,043	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: 15-1329 Component CCN: 15-8567	Period: From 01/01/2022 To 12/31/2022	Worksheet M-3 Date/Time Prepared: 5/26/2023 12:48 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)		2,694,846	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)		24,170	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)		2,670,676	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		9,689	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)		0	5.00
6.00	Total adjusted visits (line 4 plus line 5)		9,689	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		275.64	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	113.00	8.00
9.00	Rate for Program covered visits (see instructions)	0.00	113.00	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	1,239	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	140,007	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	140,007	16.00
16.01	Total program charges (see instructions)(from contractor's records)		322,542	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		25,716	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		11,163	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.)		100,098	16.04
16.05	Total program cost (see instructions)	0	111,261	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		3,721	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		58,619	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		111,261	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		10,068	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		121,329	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)		121,329	26.00
26.01	Sequestration adjustment (see instructions)		1,528	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		109,921	27.00
28.00	Tentative settlement (for contractor use only)		0	28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)		9,880	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: 15-1329 | Component CCN: 15-8511 | Period: From 01/01/2022 To 12/31/2022 | Worksheet M-4 | Date/Time Prepared: 5/26/2023 12:48 pm

Title XVIII | RHC I | Cost

		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	1,142,753	1,142,753	1,142,753	1,142,753	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000132	0.001530	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	151	1,748	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	1,977	3,944	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	2,128	5,692	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	1,273,543	1,273,543	1,273,543	1,273,543	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	1,405,694	1,405,694	1,405,694	1,405,694	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.001671	0.004469	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	2,349	6,282	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	4,477	11,974	0	0	10.00
11.00	Total number of injections/infusions (from your records)	20	232	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	223.85	51.61	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	7	70	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)	1,567	3,613	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)		16,451	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)		5,180	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 15-1329 | Component CCN: 15-8567 | Period: From 01/01/2022 To 12/31/2022 | Worksheet M-4 | Date/Time Prepared: 5/26/2023 12:48 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)	1,241,832	1,241,832	1,241,832	1,241,832	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000000	0.002113	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	0	2,624	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	0	9,061	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	0	11,685	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	1,302,865	1,302,865	1,302,865	1,302,865	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	1,391,981	1,391,981	1,391,981	1,391,981	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.000000	0.008969	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	0	12,485	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	0	24,170	0	0	10.00
11.00	Total number of injections/infusions (from your records)	0	533	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	0.00	45.35	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	0	222	0	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	0	10,068	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)		24,170	15.00
16.00	Total Program cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount to Wkst. M-3, line 21)		10,068	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 15-1329 Component CCN: 15-8511	Period: From 01/01/2022 To 12/31/2022	Worksheet M-5 Date/Time Prepared: 5/26/2023 12:48 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		303,763	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)		303,763	4.00
	TO BE COMPLETED BY CONTRACTOR			
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
	Program to Provider			
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
	Provider to Program			
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		0	6.01
6.02	SETTLEMENT TO PROGRAM		18,043	6.02
7.00	Total Medicare program liability (see instructions)		285,720	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: 15-1329 | Component CCN: 15-8567 | Period: From 01/01/2022 To 12/31/2022 | Worksheet M-5 | Date/Time Prepared: 5/26/2023 12:48 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		109,921	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)		109,921	4.00
	TO BE COMPLETED BY CONTRACTOR			
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
	Program to Provider			
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
	Provider to Program			
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		9,880	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		119,801	7.00

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