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: 15-1310	Period: From 01/01/2022 To 12/31/2022	Worksheet S Parts I-III Date/Time Prepared: 5/26/2023 3:09 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 5/26/2023 Time: 3:09 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 PARKVIEW WABASH HOSPITAL, INC. (15-1310) 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	Jeanne Wickens		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	Jeanne Wickens			2
3	Signatory Title	CFO/SVP			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	327,120	-859,893	0	0	1.00
2.00	SUBPROVIDER - IPF	0	0	0		0	2.00
3.00	SUBPROVIDER - IRF	0	0	0		0	3.00
5.00	SWING BED - SNF	0	8,268	0		0	5.00
6.00	SWING BED - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		0		0	10.00
10.01	RURAL HEALTH CLINIC II	0		58,230		0	10.01
10.02	RURAL HEALTH CLINIC III	0		124,738		0	10.02
200.00	TOTAL	0	335,388	-676,925	0	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1310 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-2 Part I Date/Time Prepared: 5/26/2023 3:09 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 10 JOHN KISSINGER DR	PO Box:			1.00
2.00	City: WABASH	State: IN	Zip Code: 46992	County: WABASH	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	PARKVIEW WABASH HOSPITAL, INC.	151310	99915	1	12/17/2001	N	O	P	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	PARKVIEW WABASH HOSPITAL SWING BEDS	15Z310	99915		12/17/2001	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
15.01	Hospital-Based Health Clinic - RHC II	RURAL HEALTH CLINIC - N.MANCHESTER	158541	99915		06/05/2019	N	N	N	15.01
15.02	Hospital-Based Health Clinic - RHC III	RURAL HEALTH CLINIC - KISSINGER	158542	99915		07/24/2019	N	N	N	15.02
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From: 1.00	To: 2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	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	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.	2	N		23.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1310 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-2 Part I | Date/Time Prepared: 5/26/2023 3:09 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: 15-1310 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-2 Part I | Date/Time Prepared: 5/26/2023 3:09 pm

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1310 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-2 Part I | Date/Time Prepared: 5/26/2023 3:09 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: 15-1310 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-2 Part I Date/Time Prepared: 5/26/2023 3:09 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	N	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: 15-1310 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-2 Part I Date/Time Prepared: 5/26/2023 3:09 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.	N	N	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.	N	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.	N	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.	N	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.	N	Y	98.06
	Rural Providers			
105.00	Does this hospital qualify as a CAH?	Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1310 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-2 Part I | Date/Time Prepared: 5/26/2023 3:09 pm

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	56,105	0	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
123.00	Did the facility and/or its subproviders (if applicable) purchase professional services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, and/or management/consulting services, from an unrelated organization? In column 1, enter "Y" for yes or "N" for no. If column 1 is "Y", were the majority of the expenses, i.e., greater than 50% of total professional services expenses, for services purchased from unrelated organizations located in a CBSA outside of the main hospital CBSA? In column 2, enter "Y" for yes or "N" for no.			123.00
	Certified Transplant Center Information			
125.00	Does this facility operate a Medicare-certified transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare-certified kidney transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare-certified heart transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare-certified liver transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare-certified lung transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare-certified pancreas transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare-certified intestinal transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare-certified islet transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is a hospital-based organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	15H032	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: PARKVIEW HEALTH SYSTEM, INC.	Contractor's Name: WISCONSIN PHYSICIANS SERVICE	Contractor's Number: 08101	141.00
142.00	Street: 10501 CORPORATE DRIVE	PO Box: 5600		142.00
143.00	City: FORT WAYNE	State: IN	Zip Code: 46845	143.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1310 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-2 Part I Date/Time Prepared: 5/26/2023 3:09 pm

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1310 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-2 Part II | Date/Time Prepared: 5/26/2023 3:09 pm

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

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

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	04/30/2023	Y	04/30/2023	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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1310 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-2 Part II | Date/Time Prepared: 5/26/2023 3:09 pm

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

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

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

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	SHANNON	ECENBARGER	41.00
42.00	Enter the employer/company name of the cost report preparer.	PARKVIEW HEALTH SYSTEM, INC.		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	N/A	SHANNON.ECENBARGER@PARKVIEW.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-1310	Period: From 01/01/2022 To 12/31/2022	Worksheet S-2 Part II Date/Time Prepared: 5/26/2023 3:09 pm

		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	REIMBURSEMENT 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: 15-1310 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-3 Part I Date/Time Prepared: 5/26/2023 3:09 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	72,024.00	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	72,024.00	0	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	43.00				0	13.00
14.00	Total (see instructions)		18	6,570	72,024.00	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						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	88.00				0	26.00
26.01	RURAL HEALTH CLINIC II	88.01				0	26.01
26.02	RURAL HEALTH CLINIC III	88.02				0	26.02
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		18				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care	30.00	0	0		0	34.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1310 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-3 Part I | Date/Time Prepared: 5/26/2023 3:09 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	927	58	3,001			1.00
2.00	HMO and other (see instructions)	1,200	315				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	31	0	89			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	20			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	958	58	3,110			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		4	108			13.00
14.00	Total (see instructions)	958	62	3,218	0.00	198.17	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						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			74			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0	0	0	0.00	0.00	26.00
26.01	RURAL HEALTH CLINIC II	2,170	71	12,573	0.00	15.47	26.01
26.02	RURAL HEALTH CLINIC III	4,491	455	43,175	0.00	33.64	26.02
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	247.28	27.00
28.00	Observation Bed Days		33	1,480			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			14			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	38			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: 15-1310 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-3 Part I | Date/Time Prepared: 5/26/2023 3:09 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	348	23	1,083	1.00
2.00	HMO and other (see instructions)			347	118		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	348	23	1,083	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						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0.00					26.00
26.01	RURAL HEALTH CLINIC II	0.00					26.01
26.02	RURAL HEALTH CLINIC III	0.00					26.02
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care						34.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-1310 | Component CCN: 15-8541 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-8 | Date/Time Prepared: 5/26/2023 3:09 pm

RHC II

				1.00		
	Clinic Address and Identification					
1.00	Street			1104 N. WAYNE ST.		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	NORTH MANCHESTER		IN	46962	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

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

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

		Provider name	CCN	
		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		WABASH				2.00
		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC	17:00	08:00	17:00	08:00	17:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 15-1310
Component CCN: 15-8541

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

Worksheet S-8

Date/Time Prepared:
5/26/2023 3:09 pm

RHC II

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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-1310 | Component CCN: 15-8542 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-8 | Date/Time Prepared: 5/26/2023 3:09 pm

RHC III

				1.00		
	Clinic Address and Identification					
1.00	Street			8 JOHN KISSINGER DR.		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	WABASH		IN	46992	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

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

				1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?			N		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.			N	0	13.00
			Provider name		CCN	
			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		WABASH				2.00
		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC	17:00	08:00	17:00	08:00	17:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 15-1310
Component CCN: 15-8542

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

Worksheet S-8

Date/Time Prepared:
5/26/2023 3:09 pm

RHC III

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

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-1310 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-10 | Date/Time Prepared: 5/26/2023 3:09 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)	0.278928	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	2,369,690	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	14,449,550	6.00
7.00	Medicaid cost (line 1 times line 6)	4,030,384	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	1,660,694	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	85,427	9.00
10.00	Stand-alone CHIP charges	516,095	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	143,953	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	58,526	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)	1,650,801	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	20,024,708	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	5,585,452	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)	3,934,651	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)	5,653,871	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	2,617,586	947,273	3,564,859	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	730,118	947,273	1,677,391	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)	730,118	947,273	1,677,391	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)	3,443,458	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	546,892	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	841,371	27.01
28.00	Non-Medicare bad debt expense (see instructions)	2,602,087	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	1,020,274	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	2,697,665	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	8,351,536	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1310 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A | Date/Time Prepared: 5/26/2023 3:09 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		4,492,650	4,492,650	-1,417,759	3,074,891	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		71,621	71,621	1,483,104	1,554,725	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,897,294	4,673,916	6,571,210	0	6,571,210	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,022,084	16,292,602	17,314,686	-65,345	17,249,341	5.00
7.00	00700	OPERATION OF PLANT	303,244	893,933	1,197,177	0	1,197,177	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	70,678	70,678	96,106	166,784	8.00
9.00	00900	HOUSEKEEPING	323,985	181,511	505,496	-96,106	409,390	9.00
10.00	01000	DIETARY	600,414	388,745	989,159	-881,613	107,546	10.00
11.00	01100	CAFETERIA	0	0	0	870,507	870,507	11.00
13.00	01300	NURSING ADMINISTRATION	542,892	6,972	549,864	0	549,864	13.00
15.00	01500	PHARMACY	714,003	145,118	859,121	0	859,121	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,321,439	765,772	3,087,211	-494,582	2,592,629	30.00
43.00	04300	NURSERY	0	0	0	104,939	104,939	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	947,162	523,870	1,471,032	0	1,471,032	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	389,643	389,643	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,205,296	731,408	1,936,704	0	1,936,704	54.00
60.00	06000	LABORATORY	0	2,243,524	2,243,524	0	2,243,524	60.00
66.00	06600	PHYSICAL THERAPY	1,150,598	46,457	1,197,055	-277,317	919,738	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	192,920	192,920	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	84,397	84,397	68.00
69.00	06900	ELECTROCARDIOLOGY	649,018	107,605	756,623	0	756,623	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,047,689	1,047,689	-937,273	110,416	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	937,273	937,273	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	4,035,418	4,035,418	0	4,035,418	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	172,711	2,355,735	2,528,446	0	2,528,446	88.01
88.02	08802	RURAL HEALTH CLINIC III	623,750	6,027,785	6,651,535	0	6,651,535	88.02
90.00	09000	CLINIC	59,359	6,211	65,570	11,106	76,676	90.00
90.01	09001	SENIOR CARE	480,668	81,903	562,571	0	562,571	90.01
91.00	09100	EMERGENCY	975,667	1,526,483	2,502,150	0	2,502,150	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,494	-38,610	-37,116	0	-37,116	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	13,991,078	46,678,996	60,670,074	0	60,670,074	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	6,543	6,543	0	6,543	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	79,957	494,697	574,654	0	574,654	192.00
192.01	19201	PV WABASH HEALTH CLINC-CASS	0	0	0	0	0	192.01
192.02	19202	PV WABASH HEALTH CLINC-N.MANCH	0	0	0	0	0	192.02
192.03	19203	PV WABASH HEALTH CLINC-KISSINGER	0	0	0	0	0	192.03
194.00	07950	FITNESS CENTER	0	0	0	0	0	194.00
194.01	07951	FOUNDATION	0	55,195	55,195	0	55,195	194.01
194.02	07952	NEW DIRECTION	0	0	0	0	0	194.02
194.03	07953	COMMUNITY & VOLUNTEER SERVICES	0	27,468	27,468	0	27,468	194.03
194.04	07956	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.04
194.05	07955	OCCUPATIONAL HEALTH	0	0	0	0	0	194.05
200.00		TOTAL (SUM OF LINES 118 through 199)	14,071,035	47,262,899	61,333,934	0	61,333,934	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1310 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A | Date/Time Prepared: 5/26/2023 3:09 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	134,483	3,209,374		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-101,269	1,453,456		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	6,571,210		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-2,952,378	14,296,963		5.00
7.00	00700	OPERATION OF PLANT	-2,165	1,195,012		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	166,784		8.00
9.00	00900	HOUSEKEEPING	0	409,390		9.00
10.00	01000	DIETARY	-8,278	99,268		10.00
11.00	01100	CAFETERIA	-324,461	546,046		11.00
13.00	01300	NURSING ADMINISTRATION	0	549,864		13.00
15.00	01500	PHARMACY	-52,422	806,699		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-391,945	2,200,684		30.00
43.00	04300	NURSERY	0	104,939		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	1,471,032		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	389,643		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-11,167	1,925,537		54.00
60.00	06000	LABORATORY	0	2,243,524		60.00
66.00	06600	PHYSICAL THERAPY	0	919,738		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	192,920		67.00
68.00	06800	SPEECH PATHOLOGY	0	84,397		68.00
69.00	06900	ELECTROCARDIOLOGY	0	756,623		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	110,416		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	937,273		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	4,035,418		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
88.01	08801	RURAL HEALTH CLINIC II	-978	2,527,468		88.01
88.02	08802	RURAL HEALTH CLINIC III	-483	6,651,052		88.02
90.00	09000	CLINIC	0	76,676		90.00
90.01	09001	SENIOR CARE	669	563,240		90.01
91.00	09100	EMERGENCY	-81,299	2,420,851		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	37,117	1		95.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-3,754,576	56,915,498		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	6,543		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	574,654		192.00
192.01	19201	PV WABASH HEALTH CLINC-CASS	0	0		192.01
192.02	19202	PV WABASH HEALTH CLINC-N.MANCH	0	0		192.02
192.03	19203	PV WABASH HEALTH CLINC-KISSINGER	0	0		192.03
194.00	07950	FITNESS CENTER	0	0		194.00
194.01	07951	FOUNDATION	0	55,195		194.01
194.02	07952	NEW DIRECTION	0	0		194.02
194.03	07953	COMMUNITY & VOLUNTEER SERVICES	0	27,468		194.03
194.04	07956	OTHER NONREIMBURSABLE COST CENTERS	0	0		194.04
194.05	07955	OCCUPATIONAL HEALTH	0	0		194.05
200.00		TOTAL (SUM OF LINES 118 through 199)	-3,754,576	57,579,358		200.00

RECLASSIFICATIONS | Provider CCN: 15-1310 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-6 | Date/Time Prepared: 5/26/2023 3:09 pm

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - Rehab Therapy				
1.00	OCCUPATIONAL THERAPY	67.00	185,433	7,487	1.00
2.00	SPEECH PATHOLOGY	68.00	81,122	3,275	2.00
	TOTALS		266,555	10,762	
	B - Clinic Dietician				
1.00	CLINIC	90.00	11,106		1.00
			11,106	0	
	C - Cafeteria				
1.00	CAFETERIA	11.00	524,508	345,999	1.00
			524,508	345,999	
	D - Salary				
1.00	ADMINISTRATIVE & GENERAL	5.00	3,959,103		1.00
			3,959,103	0	
	E - Depreciation				
1.00	CAP REL COSTS-MVBLE EQUIP	2.00		1,454,881	1.00
			0	1,454,881	
	F - Implantable Devices				
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00		937,273	1.00
			0	937,273	
	G - Insurance				
1.00	CAP REL COSTS-BLDG & FIXT	1.00		37,122	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00		28,223	2.00
			0	65,345	
	H - OB Dept. 6101				
1.00	NURSERY	43.00	89,114	15,825	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	330,884	58,759	2.00
			419,998	74,584	
	I - Laundry				
1.00	LAUNDRY & LINEN SERVICE	8.00		96,106	1.00
			0	96,106	
	J - N. Manchester RHC Salary				
1.00	RURAL HEALTH CLINIC II	88.01	1,181,378		1.00
			1,181,378	0	
	K - Kissinger RHC Salary				
1.00	RURAL HEALTH CLINIC III	88.02	2,728,528		1.00
			2,728,528	0	
500.00	Grand Total: Increases		9,091,176	2,984,950	500.00

RECLASSIFICATIONS | Provider CCN: 15-1310 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-6 | Date/Time Prepared: 5/26/2023 3:09 pm

		Decreases				
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	A - Rehab Therapy					
1.00	PHYSICAL THERAPY	66.00	266,555	10,762	0	1.00
2.00		0.00	0	0	0	2.00
	TOTALS		266,555	10,762		
	B - Clinic Dietician					
1.00	DIETARY	10.00	11,106			1.00
			11,106	0		
	C - Cafeteria					
1.00	DIETARY	10.00	524,508	345,999		1.00
			524,508	345,999		
	D - Salary					
1.00	ADMINISTRATIVE & GENERAL	5.00		3,959,103		1.00
			0	3,959,103		
	E - Depreciation					
1.00	CAP REL COSTS-BLDG & FIXT	1.00		1,454,881	9	1.00
			0	1,454,881		
	F - Implantable Devices					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00		937,273		1.00
			0	937,273		
	G - Insurance					
1.00	ADMINISTRATIVE & GENERAL	5.00		65,345	12	1.00
2.00					12	2.00
			0	65,345		
	H - OB Dept. 6101					
1.00	ADULTS & PEDIATRICS	30.00	419,998	74,584		1.00
2.00						2.00
			419,998	74,584		
	I - Laundry					
1.00	HOUSEKEEPING	9.00		96,106		1.00
			0	96,106		
	J - N. Manchester RHC Salary					
1.00	RURAL HEALTH CLINIC II	88.01		1,181,378		1.00
			0	1,181,378		
	K - Kissinger RHC Salary					
1.00	RURAL HEALTH CLINIC III	88.02		2,728,528		1.00
			0	2,728,528		
500.00	Grand Total: Decreases		1,222,167	10,853,959		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1310 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-7 Part I | Date/Time Prepared: 5/26/2023 3:09 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	1,518,481	0	0	0	0	1.00
2.00	Land Improvements	2,143,602	0	0	0	0	2.00
3.00	Buildings and Fixtures	24,083,380	36,116	0	36,116	282,752	3.00
4.00	Building Improvements	4,150,859	282,752	0	282,752	0	4.00
5.00	Fixed Equipment	3,459,738	63,579	0	63,579	119,158	5.00
6.00	Movable Equipment	24,393,396	374,574	0	374,574	0	6.00
7.00	HIT designated Assets	2,598,132	61,239	0	61,239	0	7.00
8.00	Subtotal (sum of lines 1-7)	62,347,588	818,260	0	818,260	401,910	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	62,347,588	818,260	0	818,260	401,910	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	1,518,481	0	1.00
2.00	Land Improvements	2,143,602	314,699	2.00
3.00	Buildings and Fixtures	23,836,744	12,521,286	3.00
4.00	Building Improvements	4,433,611	3,809,797	4.00
5.00	Fixed Equipment	3,404,159	1,472,620	5.00
6.00	Movable Equipment	24,767,970	14,675,393	6.00
7.00	HIT designated Assets	2,659,371	1,443,626	7.00
8.00	Subtotal (sum of lines 1-7)	62,763,938	34,237,421	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	62,763,938	34,237,421	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1310 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-7 Part II Date/Time Prepared: 5/26/2023 3:09 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	3,560,082	140,622	707,269	0	84,677	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	71,621	0	0	0	2.00
3.00	Total (sum of lines 1-2)	3,560,082	212,243	707,269	0	84,677	3.00

	Cost Center Description	SUMMARY OF CAPITAL		
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	4,492,650	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	71,621	2.00
3.00	Total (sum of lines 1-2)	0	4,564,271	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1310 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-7 Part III Date/Time Prepared: 5/26/2023 3:09 pm

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	35,336,598	0	35,336,598	0.594536	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	24,767,970	668,964	24,099,006	0.405464	0	2.00
3.00	Total (sum of lines 1-2)	60,104,568	668,964	59,435,604	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	2,239,684	140,622	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	1,353,612	71,621	2.00
3.00	Total (sum of lines 1-2)	0	0	0	3,593,296	212,243	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	707,269	37,122	84,677	0	3,209,374	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	28,223	0	0	1,453,456	2.00
3.00	Total (sum of lines 1-2)	707,269	65,345	84,677	0	4,662,830	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1310 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-8 | Date/Time Prepared: 5/26/2023 3:09 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		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)	A	-2,165	OPERATION OF PLANT	7.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-506,130			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	309,814			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-324,461	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients	B	-46,136	PHARMACY	15.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1310 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-8 | Date/Time Prepared: 5/26/2023 3:09 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	A	-3,399	CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00	340B Retail	B	-6,286	PHARMACY	15.00	0	33.00
33.01	Other Operating Revenue - Admin	B	-395	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02	Other Operating Revenue - Dietary	B	-8,278	DIETARY	10.00	0	33.02
33.03	Other Operating Revenue - Radiology	B	-42	RADIOLOGY-DIAGNOSTIC	54.00	0	33.03
33.04	TV Depreciation	A	-40,028	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.04
33.05	Lobbying	A	-4,951	ADMINISTRATIVE & GENERAL	5.00	0	33.05
33.07	Depreciation - Old Hospital	A	134,483	CAP REL COSTS-BLDG & FIXT	1.00	9	33.07
33.08	Depreciation - Old Hospital	A	-57,842	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.08
33.09	PPG Admin Physician Salaries	A	38,474	ADMINISTRATIVE & GENERAL	5.00	0	33.09
33.10	Telemetry Monitoring	A	33,555	ADULTS & PEDIATRICS	30.00	0	33.10
33.14	EMS Adjustment	A	37,117	AMBULANCE SERVICES	95.00	0	33.14
33.15	HAF Expense Adjustment	A	-3,267,827	ADMINISTRATIVE & GENERAL	5.00	0	33.15
33.17	Cass RHC	A	-23,403	ADMINISTRATIVE & GENERAL	5.00	0	33.17
33.18	HeartSmart Scan Reads	A	-11,125	RADIOLOGY-DIAGNOSTIC	54.00	0	33.18
33.21	Lobbying	A	-978	RURAL HEALTH CLINIC II	88.01	0	33.21
33.22	Lobbying	A	-483	RURAL HEALTH CLINIC III	88.02	0	33.22
33.23	SPONSORSHIPS	A	-1,590	ADMINISTRATIVE & GENERAL	5.00	0	33.23
33.24	COMMUNITY BENEFIT EXPENSE	A	-2,500	ADMINISTRATIVE & GENERAL	5.00	0	33.24
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-3,754,576				50.00

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 15-1310 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-8-1 | Date/Time Prepared: 5/26/2023 3:09 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	5.00	ADMINISTRATIVE & GENERAL	Home Office Allocation	12,269,618	8,734,830	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	Related Party Subsidy (PPG)	0	3,224,974	2.00
3.00	0.00			0	0	3.00
4.00	0.00			0	0	4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			12,269,618	11,959,804	5.00

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

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

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

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

6.00	G	Parkview Health	1.00	Parkview Health	1.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:	Home Office				100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 15-1310 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-8-1 | Date/Time Prepared: 5/26/2023 3:09 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	3,534,788	0		1.00
2.00	-3,224,974	0		2.00
3.00	0	0		3.00
4.00	0	0		4.00
5.00	309,814			5.00

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

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

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

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

6.00	Home Office		6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-1310 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-8-2 | Date/Time Prepared: 5/26/2023 3:09 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	21,500	21,500	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	404,000	404,000	0	0	0	2.00
3.00	90.01	SENIOR CARE	-669	-669	0	0	0	3.00
4.00	91.00	EMERGENCY	186,480	81,299	105,181	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			611,311	506,130	105,181		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	90.01	SENIOR CARE	0	0	0	0	0	3.00
4.00	91.00	EMERGENCY	0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	21,500		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	404,000		2.00
3.00	90.01	SENIOR CARE	0	0	0	-669		3.00
4.00	91.00	EMERGENCY	0	0	0	81,299		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	506,130		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1310 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part I | Date/Time Prepared: 5/26/2023 3:09 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	3,209,374	3,209,374				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,453,456		1,453,456			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	6,571,210	0	0	6,571,210		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	14,296,963	885,412	400,983	1,633,124	17,216,482	5.00
7.00	00700	OPERATION OF PLANT	1,195,012	367,070	166,238	99,422	1,827,742	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	166,784	0	0	0	166,784	8.00
9.00	00900	HOUSEKEEPING	409,390	69,168	31,325	106,222	616,105	9.00
10.00	01000	DIETARY	99,268	79,327	35,926	21,245	235,766	10.00
11.00	01100	CAFETERIA	546,046	141,611	64,133	171,965	923,755	11.00
13.00	01300	NURSING ADMINISTRATION	549,864	6,096	2,761	177,993	736,714	13.00
15.00	01500	PHARMACY	806,699	117,021	52,996	234,093	1,210,809	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,200,684	295,041	133,618	623,406	3,252,749	30.00
43.00	04300	NURSERY	104,939	4,271	1,934	29,217	140,361	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,471,032	312,748	141,637	310,537	2,235,954	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	389,643	27,991	12,676	108,484	538,794	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,925,537	263,526	119,345	395,168	2,703,576	54.00
60.00	06000	LABORATORY	2,243,524	144,473	65,429	0	2,453,426	60.00
66.00	06600	PHYSICAL THERAPY	919,738	11,777	5,333	289,842	1,226,690	66.00
67.00	06700	OCCUPATIONAL THERAPY	192,920	2,488	1,127	60,796	257,331	67.00
68.00	06800	SPEECH PATHOLOGY	84,397	1,078	488	26,597	112,560	68.00
69.00	06900	ELECTROCARDIOLOGY	756,623	118,473	53,654	212,787	1,141,537	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	110,416	0	0	0	110,416	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	937,273	0	0	0	937,273	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,035,418	0	0	0	4,035,418	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	2,527,468	0	0	443,952	2,971,420	88.01
88.02	08802	RURAL HEALTH CLINIC III	6,651,052	0	0	1,099,078	7,750,130	88.02
90.00	09000	CLINIC	76,676	4,727	2,141	23,103	106,647	90.00
90.01	09001	SENIOR CARE	563,240	88,284	39,982	157,592	849,098	90.01
91.00	09100	EMERGENCY	2,420,851	241,589	109,411	319,882	3,091,733	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1	0	0	490	491	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	56,915,498	3,182,171	1,441,137	6,544,995	56,849,761	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	6,543	16,504	7,474	0	30,521	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	574,654	0	0	26,215	600,869	192.00
192.01	19201	PV WABASH HEALTH CLINC-CASS	0	0	0	0	0	192.01
192.02	19202	PV WABASH HEALTH CLINC-N.MANCH	0	0	0	0	0	192.02
192.03	19203	PV WABASH HEALTH CLINC-KISSINGER	0	0	0	0	0	192.03
194.00	07950	FITNESS CENTER	0	0	0	0	0	194.00
194.01	07951	FOUNDATION	55,195	10,699	4,845	0	70,739	194.01
194.02	07952	NEW DIRECTION	0	0	0	0	0	194.02
194.03	07953	COMMUNITY & VOLUNTEER SERVICES	27,468	0	0	0	27,468	194.03
194.04	07956	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.04
194.05	07955	OCCUPATIONAL HEALTH	0	0	0	0	0	194.05
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	57,579,358	3,209,374	1,453,456	6,571,210	57,579,358	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1310 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part I | Date/Time Prepared: 5/26/2023 3:09 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	17,216,482					5.00
7.00	00700	OPERATION OF PLANT	779,609	2,607,351				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	71,140	0	237,924			8.00
9.00	00900	HOUSEKEEPING	262,795	92,159	0	971,059		9.00
10.00	01000	DIETARY	100,564	105,695	0	40,807	482,832	10.00
11.00	01100	CAFETERIA	394,020	188,682	0	72,846	0	11.00
13.00	01300	NURSING ADMINISTRATION	314,239	8,122	0	3,136	0	13.00
15.00	01500	PHARMACY	516,461	155,918	424	60,197	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,387,434	393,111	65,712	151,771	482,832	30.00
43.00	04300	NURSERY	59,870	5,691	1,489	2,197	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	953,728	416,704	29,326	160,878	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	229,818	37,294	5,510	14,399	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,153,189	351,120	49,276	135,560	0	54.00
60.00	06000	LABORATORY	1,046,489	192,495	0	74,318	0	60.00
66.00	06600	PHYSICAL THERAPY	523,235	15,691	0	6,058	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	109,762	3,315	0	1,280	0	67.00
68.00	06800	SPEECH PATHOLOGY	48,012	1,437	0	555	0	68.00
69.00	06900	ELECTROCARDIOLOGY	486,913	157,852	0	60,943	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	47,097	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	399,786	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,721,275	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	1,267,435	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	3,305,780	0	0	0	0	88.02
90.00	09000	CLINIC	45,489	6,299	0	2,432	0	90.00
90.01	09001	SENIOR CARE	362,176	117,629	0	45,414	0	90.01
91.00	09100	EMERGENCY	1,318,754	321,892	86,187	124,275	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	209	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	16,905,279	2,571,106	237,924	957,066	482,832	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	13,018	21,990	0	8,490	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	256,296	0	0	0	0	192.00
192.01	19201	PV WABASH HEALTH CLINC-CASS	0	0	0	0	0	192.01
192.02	19202	PV WABASH HEALTH CLINC-N.MANCH	0	0	0	0	0	192.02
192.03	19203	PV WABASH HEALTH CLINC-KISSINGER	0	0	0	0	0	192.03
194.00	07950	FITNESS CENTER	0	0	0	0	0	194.00
194.01	07951	FOUNDATION	30,173	14,255	0	5,503	0	194.01
194.02	07952	NEW DIRECTION	0	0	0	0	0	194.02
194.03	07953	COMMUNITY & VOLUNTEER SERVICES	11,716	0	0	0	0	194.03
194.04	07956	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.04
194.05	07955	OCCUPATIONAL HEALTH	0	0	0	0	0	194.05
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)	17,216,482	2,607,351	237,924	971,059	482,832	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1310 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part I | Date/Time Prepared: 5/26/2023 3:09 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	
			11.00	13.00	15.00	16.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	1,579,303					11.00
13.00	01300	NURSING ADMINISTRATION	58,041	1,120,252				13.00
15.00	01500	PHARMACY	99,574	0	2,043,383			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	345,629	516,683	0	0	6,595,921	30.00
43.00	04300	NURSERY	13,626	20,445	0	0	243,679	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	159,057	237,821	0	0	4,193,468	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	50,835	75,924	0	0	952,574	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	244,350	0	0	0	4,637,071	54.00
60.00	06000	LABORATORY	0	0	0	0	3,766,728	60.00
66.00	06600	PHYSICAL THERAPY	176,614	0	0	0	1,948,288	66.00
67.00	06700	OCCUPATIONAL THERAPY	22,142	0	0	0	393,830	67.00
68.00	06800	SPEECH PATHOLOGY	11,792	0	0	0	174,356	68.00
69.00	06900	ELECTROCARDIOLOGY	101,409	0	0	0	1,948,654	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	157,513	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	1,337,059	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	2,043,383	0	7,800,076	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	4,238,855	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	11,055,910	88.02
90.00	09000	CLINIC	18,474	0	0	0	179,341	90.00
90.01	09001	SENIOR CARE	97,609	0	0	0	1,471,926	90.01
91.00	09100	EMERGENCY	180,151	269,379	0	0	5,392,371	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	700	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,579,303	1,120,252	2,043,383	0	56,488,320	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	74,019	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	857,165	192.00
192.01	19201	PV WABASH HEALTH CLINC-CASS	0	0	0	0	0	192.01
192.02	19202	PV WABASH HEALTH CLINC-N.MANCH	0	0	0	0	0	192.02
192.03	19203	PV WABASH HEALTH CLINC-KISSINGER	0	0	0	0	0	192.03
194.00	07950	FITNESS CENTER	0	0	0	0	0	194.00
194.01	07951	FOUNDATION	0	0	0	0	120,670	194.01
194.02	07952	NEW DIRECTION	0	0	0	0	0	194.02
194.03	07953	COMMUNITY & VOLUNTEER SERVICES	0	0	0	0	39,184	194.03
194.04	07956	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.04
194.05	07955	OCCUPATIONAL HEALTH	0	0	0	0	0	194.05
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)	1,579,303	1,120,252	2,043,383	0	57,579,358	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1310 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part I | Date/Time Prepared: 5/26/2023 3:09 pm

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
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	6,595,921		30.00
43.00	04300	NURSERY	0	243,679		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	4,193,468		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	952,574		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	4,637,071		54.00
60.00	06000	LABORATORY	0	3,766,728		60.00
66.00	06600	PHYSICAL THERAPY	0	1,948,288		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	393,830		67.00
68.00	06800	SPEECH PATHOLOGY	0	174,356		68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,948,654		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	157,513		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,337,059		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	7,800,076		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	4,238,855		88.01
88.02	08802	RURAL HEALTH CLINIC III	0	11,055,910		88.02
90.00	09000	CLINIC	0	179,341		90.00
90.01	09001	SENIOR CARE	0	1,471,926		90.01
91.00	09100	EMERGENCY	0	5,392,371		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0			92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	700		95.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	56,488,320		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	74,019		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	857,165		192.00
192.01	19201	PV WABASH HEALTH CLINC-CASS	0	0		192.01
192.02	19202	PV WABASH HEALTH CLINC-N.MANCH	0	0		192.02
192.03	19203	PV WABASH HEALTH CLINC-KISSINGER	0	0		192.03
194.00	07950	FITNESS CENTER	0	0		194.00
194.01	07951	FOUNDATION	0	120,670		194.01
194.02	07952	NEW DIRECTION	0	0		194.02
194.03	07953	COMMUNITY & VOLUNTEER SERVICES	0	39,184		194.03
194.04	07956	OTHER NONREIMBURSABLE COST CENTERS	0	0		194.04
194.05	07955	OCCUPATIONAL HEALTH	0	0		194.05
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	57,579,358		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1310 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part II | Date/Time Prepared: 5/26/2023 3:09 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,513,726	885,412	400,983	3,800,121	0	5.00
7.00	00700	OPERATION OF PLANT	0	367,070	166,238	533,308	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	69,168	31,325	100,493	0	9.00
10.00	01000	DIETARY	0	79,327	35,926	115,253	0	10.00
11.00	01100	CAFETERIA	0	141,611	64,133	205,744	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	6,096	2,761	8,857	0	13.00
15.00	01500	PHARMACY	0	117,021	52,996	170,017	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	295,041	133,618	428,659	0	30.00
43.00	04300	NURSERY	0	4,271	1,934	6,205	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	312,748	141,637	454,385	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	27,991	12,676	40,667	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	263,526	119,345	382,871	0	54.00
60.00	06000	LABORATORY	0	144,473	65,429	209,902	0	60.00
66.00	06600	PHYSICAL THERAPY	0	11,777	5,333	17,110	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,488	1,127	3,615	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,078	488	1,566	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	118,473	53,654	172,127	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	17,505	0	0	17,505	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	67,245	0	0	67,245	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	397,050	0	0	397,050	0	88.02
90.00	09000	CLINIC	0	4,727	2,141	6,868	0	90.00
90.01	09001	SENIOR CARE	0	88,284	39,982	128,266	0	90.01
91.00	09100	EMERGENCY	0	241,589	109,411	351,000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,995,526	3,182,171	1,441,137	7,618,834	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	16,504	7,474	23,978	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	427,132	0	0	427,132	0	192.00
192.01	19201	PV WABASH HEALTH CLINC-CASS	0	0	0	0	0	192.01
192.02	19202	PV WABASH HEALTH CLINC-N.MANCH	0	0	0	0	0	192.02
192.03	19203	PV WABASH HEALTH CLINC-KISSINGER	0	0	0	0	0	192.03
194.00	07950	FITNESS CENTER	0	0	0	0	0	194.00
194.01	07951	FOUNDATION	0	10,699	4,845	15,544	0	194.01
194.02	07952	NEW DIRECTION	0	0	0	0	0	194.02
194.03	07953	COMMUNITY & VOLUNTEER SERVICES	0	0	0	0	0	194.03
194.04	07956	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.04
194.05	07955	OCCUPATIONAL HEALTH	0	0	0	0	0	194.05
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	3,422,658	3,209,374	1,453,456	8,085,488	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1310 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part II | Date/Time Prepared: 5/26/2023 3:09 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,800,121					5.00
7.00	00700	OPERATION OF PLANT	172,080	705,388				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	15,703	0	15,703			8.00
9.00	00900	HOUSEKEEPING	58,006	24,932	0	183,431		9.00
10.00	01000	DIETARY	22,197	28,595	0	7,708	173,753	10.00
11.00	01100	CAFETERIA	86,971	51,046	0	13,760	0	11.00
13.00	01300	NURSING ADMINISTRATION	69,361	2,197	0	592	0	13.00
15.00	01500	PHARMACY	113,996	42,182	28	11,371	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	306,243	106,352	4,337	28,669	173,753	30.00
43.00	04300	NURSERY	13,215	1,540	98	415	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	210,513	112,734	1,936	30,391	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	50,727	10,090	364	2,720	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	254,539	94,991	3,252	25,607	0	54.00
60.00	06000	LABORATORY	230,988	52,077	0	14,038	0	60.00
66.00	06600	PHYSICAL THERAPY	115,492	4,245	0	1,144	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	24,227	897	0	242	0	67.00
68.00	06800	SPEECH PATHOLOGY	10,597	389	0	105	0	68.00
69.00	06900	ELECTROCARDIOLOGY	107,475	42,705	0	11,512	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	10,396	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	88,243	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	379,931	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	279,756	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	729,661	0	0	0	0	88.02
90.00	09000	CLINIC	10,041	1,704	0	459	0	90.00
90.01	09001	SENIOR CARE	79,942	31,823	0	8,579	0	90.01
91.00	09100	EMERGENCY	291,084	87,084	5,688	23,475	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	46	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,731,430	695,583	15,703	180,787	173,753	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,874	5,949	0	1,604	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	56,571	0	0	0	0	192.00
192.01	19201	PV WABASH HEALTH CLINC-CASS	0	0	0	0	0	192.01
192.02	19202	PV WABASH HEALTH CLINC-N.MANCH	0	0	0	0	0	192.02
192.03	19203	PV WABASH HEALTH CLINC-KISSINGER	0	0	0	0	0	192.03
194.00	07950	FITNESS CENTER	0	0	0	0	0	194.00
194.01	07951	FOUNDATION	6,660	3,856	0	1,040	0	194.01
194.02	07952	NEW DIRECTION	0	0	0	0	0	194.02
194.03	07953	COMMUNITY & VOLUNTEER SERVICES	2,586	0	0	0	0	194.03
194.04	07956	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.04
194.05	07955	OCCUPATIONAL HEALTH	0	0	0	0	0	194.05
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)	3,800,121	705,388	15,703	183,431	173,753	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1310 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part II | Date/Time Prepared: 5/26/2023 3:09 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	
			11.00	13.00	15.00	16.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	357,521					11.00
13.00	01300	NURSING ADMINISTRATION	13,139	94,146				13.00
15.00	01500	PHARMACY	22,542	0	360,136			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	78,242	43,422	0	0	1,169,677	30.00
43.00	04300	NURSERY	3,085	1,718	0	0	26,276	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	36,007	19,986	0	0	865,952	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	11,508	6,381	0	0	122,457	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	55,316	0	0	0	816,576	54.00
60.00	06000	LABORATORY	0	0	0	0	507,005	60.00
66.00	06600	PHYSICAL THERAPY	39,982	0	0	0	177,973	66.00
67.00	06700	OCCUPATIONAL THERAPY	5,013	0	0	0	33,994	67.00
68.00	06800	SPEECH PATHOLOGY	2,669	0	0	0	15,326	68.00
69.00	06900	ELECTROCARDIOLOGY	22,957	0	0	0	356,776	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	10,396	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	88,243	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	360,136	0	740,067	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	17,505	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	347,001	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	1,126,711	88.02
90.00	09000	CLINIC	4,182	0	0	0	23,254	90.00
90.01	09001	SENIOR CARE	22,097	0	0	0	270,707	90.01
91.00	09100	EMERGENCY	40,782	22,639	0	0	821,752	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	46	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	357,521	94,146	360,136	0	7,537,694	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	34,405	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	483,703	192.00
192.01	19201	PV WABASH HEALTH CLINC-CASS	0	0	0	0	0	192.01
192.02	19202	PV WABASH HEALTH CLINC-N.MANCH	0	0	0	0	0	192.02
192.03	19203	PV WABASH HEALTH CLINC-KISSINGER	0	0	0	0	0	192.03
194.00	07950	FITNESS CENTER	0	0	0	0	0	194.00
194.01	07951	FOUNDATION	0	0	0	0	27,100	194.01
194.02	07952	NEW DIRECTION	0	0	0	0	0	194.02
194.03	07953	COMMUNITY & VOLUNTEER SERVICES	0	0	0	0	2,586	194.03
194.04	07956	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.04
194.05	07955	OCCUPATIONAL HEALTH	0	0	0	0	0	194.05
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)	357,521	94,146	360,136	0	8,085,488	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1310 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part II | Date/Time Prepared: 5/26/2023 3:09 pm

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
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	1,169,677		30.00
43.00	04300	NURSERY	0	26,276		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	865,952		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	122,457		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	816,576		54.00
60.00	06000	LABORATORY	0	507,005		60.00
66.00	06600	PHYSICAL THERAPY	0	177,973		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	33,994		67.00
68.00	06800	SPEECH PATHOLOGY	0	15,326		68.00
69.00	06900	ELECTROCARDIOLOGY	0	356,776		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	10,396		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	88,243		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	740,067		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	17,505		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	347,001		88.01
88.02	08802	RURAL HEALTH CLINIC III	0	1,126,711		88.02
90.00	09000	CLINIC	0	23,254		90.00
90.01	09001	SENIOR CARE	0	270,707		90.01
91.00	09100	EMERGENCY	0	821,752		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0			92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	46		95.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	7,537,694		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	34,405		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	483,703		192.00
192.01	19201	PV WABASH HEALTH CLINC-CASS	0	0		192.01
192.02	19202	PV WABASH HEALTH CLINC-N.MANCH	0	0		192.02
192.03	19203	PV WABASH HEALTH CLINC-KISSINGER	0	0		192.03
194.00	07950	FITNESS CENTER	0	0		194.00
194.01	07951	FOUNDATION	0	27,100		194.01
194.02	07952	NEW DIRECTION	0	0		194.02
194.03	07953	COMMUNITY & VOLUNTEER SERVICES	0	2,586		194.03
194.04	07956	OTHER NONREIMBURSABLE COST CENTERS	0	0		194.04
194.05	07955	OCCUPATIONAL HEALTH	0	0		194.05
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	8,085,488		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1310 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B-1 | Date/Time Prepared: 5/26/2023 3:09 pm

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	77,395					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		77,395				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	20,042,750			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	21,352	21,352	4,981,187	-17,216,482	40,362,876	5.00
7.00	00700	OPERATION OF PLANT	8,852	8,852	303,244	0	1,827,742	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	166,784	8.00
9.00	00900	HOUSEKEEPING	1,668	1,668	323,985	0	616,105	9.00
10.00	01000	DIETARY	1,913	1,913	64,800	0	235,766	10.00
11.00	01100	CAFETERIA	3,415	3,415	524,508	0	923,755	11.00
13.00	01300	NURSING ADMINISTRATION	147	147	542,892	0	736,714	13.00
15.00	01500	PHARMACY	2,822	2,822	714,003	0	1,210,809	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,115	7,115	1,901,441	0	3,252,749	30.00
43.00	04300	NURSERY	103	103	89,114	0	140,361	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,542	7,542	947,162	0	2,235,954	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	675	675	330,884	0	538,794	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,355	6,355	1,205,296	0	2,703,576	54.00
60.00	06000	LABORATORY	3,484	3,484	0	0	2,453,426	60.00
66.00	06600	PHYSICAL THERAPY	284	284	884,043	0	1,226,690	66.00
67.00	06700	OCCUPATIONAL THERAPY	60	60	185,433	0	257,331	67.00
68.00	06800	SPEECH PATHOLOGY	26	26	81,122	0	112,560	68.00
69.00	06900	ELECTROCARDIOLOGY	2,857	2,857	649,018	0	1,141,537	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	110,416	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	937,273	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	4,035,418	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	1,354,089	0	2,971,420	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	3,352,278	0	7,750,130	88.02
90.00	09000	CLINIC	114	114	70,465	0	106,647	90.00
90.01	09001	SENIOR CARE	2,129	2,129	480,668	0	849,098	90.01
91.00	09100	EMERGENCY	5,826	5,826	975,667	0	3,091,733	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	1,494	0	491	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	76,739	76,739	19,962,793	-17,216,482	39,633,279	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	398	398	0	0	30,521	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	79,957	0	600,869	192.00
192.01	19201	PV WABASH HEALTH CLINC-CASS	0	0	0	0	0	192.01
192.02	19202	PV WABASH HEALTH CLINC-N.MANCH	0	0	0	0	0	192.02
192.03	19203	PV WABASH HEALTH CLINC-KISSINGER	0	0	0	0	0	192.03
194.00	07950	FITNESS CENTER	0	0	0	0	0	194.00
194.01	07951	FOUNDATION	258	258	0	0	70,739	194.01
194.02	07952	NEW DIRECTION	0	0	0	0	0	194.02
194.03	07953	COMMUNITY & VOLUNTEER SERVICES	0	0	0	0	27,468	194.03
194.04	07956	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.04
194.05	07955	OCCUPATIONAL HEALTH	0	0	0	0	0	194.05
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	3,209,374	1,453,456	6,571,210		17,216,482	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	41.467459	18.779714	0.327860		0.426542	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			0		3,800,121	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000000		0.094149	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: 15-1310 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B-1 | Date/Time Prepared: 5/26/2023 3:09 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDR)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (HOURS)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	47,191					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	23,017				8.00
9.00	00900	HOUSEKEEPING	1,668	0	45,523			9.00
10.00	01000	DIETARY	1,913	0	1,913	15,775		10.00
11.00	01100	CAFETERIA	3,415	0	3,415	0	12,054	11.00
13.00	01300	NURSING ADMINISTRATION	147	0	147	0	443	13.00
15.00	01500	PHARMACY	2,822	41	2,822	0	760	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,115	6,357	7,115	15,775	2,638	30.00
43.00	04300	NURSERY	103	144	103	0	104	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,542	2,837	7,542	0	1,214	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	675	533	675	0	388	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,355	4,767	6,355	0	1,865	54.00
60.00	06000	LABORATORY	3,484	0	3,484	0	0	60.00
66.00	06600	PHYSICAL THERAPY	284	0	284	0	1,348	66.00
67.00	06700	OCCUPATIONAL THERAPY	60	0	60	0	169	67.00
68.00	06800	SPEECH PATHOLOGY	26	0	26	0	90	68.00
69.00	06900	ELECTROCARDIOLOGY	2,857	0	2,857	0	774	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
90.00	09000	CLINIC	114	0	114	0	141	90.00
90.01	09001	SENIOR CARE	2,129	0	2,129	0	745	90.01
91.00	09100	EMERGENCY	5,826	8,338	5,826	0	1,375	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	46,535	23,017	44,867	15,775	12,054	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	398	0	398	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	PV WABASH HEALTH CLINC-CASS	0	0	0	0	0	192.01
192.02	19202	PV WABASH HEALTH CLINC-N.MANCH	0	0	0	0	0	192.02
192.03	19203	PV WABASH HEALTH CLINC-KISSINGER	0	0	0	0	0	192.03
194.00	07950	FITNESS CENTER	0	0	0	0	0	194.00
194.01	07951	FOUNDATION	258	0	258	0	0	194.01
194.02	07952	NEW DIRECTION	0	0	0	0	0	194.02
194.03	07953	COMMUNITY & VOLUNTEER SERVICES	0	0	0	0	0	194.03
194.04	07956	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.04
194.05	07955	OCCUPATIONAL HEALTH	0	0	0	0	0	194.05
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)	2,607,351	237,924	971,059	482,832	1,579,303	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	55.251022	10.336881	21.331173	30.607417	131.018998	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	705,388	15,703	183,431	173,753	357,521	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	14.947511	0.682235	4.029414	11.014453	29.659947	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: 15-1310 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B-1 | Date/Time Prepared: 5/26/2023 3:09 pm

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NRS ING HR)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS REV)		
			13.00	15.00	16.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION	118,954				13.00
15.00	01500	PHARMACY	0	25,519			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	54,864	0	0		30.00
43.00	04300	NURSERY	2,171	0	0		43.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	25,253	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	8,062	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
60.00	06000	LABORATORY	0	0	0		60.00
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	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	25,519	0		73.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0		88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0		88.02
90.00	09000	CLINIC	0	0	0		90.00
90.01	09001	SENIOR CARE	0	0	0		90.01
91.00	09100	EMERGENCY	28,604	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	0	0		95.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118,954	25,519	0		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0		192.00
192.01	19201	PV WABASH HEALTH CLINC-CASS	0	0	0		192.01
192.02	19202	PV WABASH HEALTH CLINC-N.MANCH	0	0	0		192.02
192.03	19203	PV WABASH HEALTH CLINC-KISSINGER	0	0	0		192.03
194.00	07950	FITNESS CENTER	0	0	0		194.00
194.01	07951	FOUNDATION	0	0	0		194.01
194.02	07952	NEW DIRECTION	0	0	0		194.02
194.03	07953	COMMUNITY & VOLUNTEER SERVICES	0	0	0		194.03
194.04	07956	OTHER NONREIMBURSABLE COST CENTERS	0	0	0		194.04
194.05	07955	OCCUPATIONAL HEALTH	0	0	0		194.05
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,120,252	2,043,383	0		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	9.417523	80.073004	0.000000		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	94,146	360,136	0		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.791449	14.112465	0.000000		205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)					206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)					207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1310 | Period: From 01/01/2022 To 12/31/2022 | Worksheet C Part I Date/Time Prepared: 5/26/2023 3:09 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	6,595,921		6,595,921	0	0	30.00
43.00	04300	NURSERY	243,679		243,679	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,193,468		4,193,468	0	0	50.00
51.00	05100	RECOVERY ROOM	0		0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	952,574		952,574	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,637,071		4,637,071	0	0	54.00
60.00	06000	LABORATORY	3,766,728		3,766,728	0	0	60.00
66.00	06600	PHYSICAL THERAPY	1,948,288	0	1,948,288	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	393,830	0	393,830	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	174,356	0	174,356	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,948,654		1,948,654	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	157,513		157,513	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,337,059		1,337,059	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,800,076		7,800,076	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0		0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	4,238,855		4,238,855	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	11,055,910		11,055,910	0	0	88.02
90.00	09000	CLINIC	179,341		179,341	0	0	90.00
90.01	09001	SENIOR CARE	1,471,926		1,471,926	0	0	90.01
91.00	09100	EMERGENCY	5,392,371		5,392,371	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,134,471		2,134,471		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	700		700	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	58,622,791	0	58,622,791	0	0	200.00
201.00		Less Observation Beds	2,134,471		2,134,471		0	201.00
202.00		Total (see instructions)	56,488,320	0	56,488,320	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1310 | Period: From 01/01/2022 To 12/31/2022 | Worksheet C Part I Date/Time Prepared: 5/26/2023 3:09 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	6,248,437		6,248,437			30.00
43.00	04300	NURSERY	236,211		236,211			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,517,730	13,434,883	15,952,613	0.262870	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	801,801	82,417	884,218	1.077307	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,641,703	33,131,884	34,773,587	0.133350	0.000000	54.00
60.00	06000	LABORATORY	2,852,510	25,012,183	27,864,693	0.135179	0.000000	60.00
66.00	06600	PHYSICAL THERAPY	365,443	4,920,959	5,286,402	0.368547	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	269,415	499,377	768,792	0.512271	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	94,290	303,135	397,425	0.438714	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	2,268,743	6,525,618	8,794,361	0.221580	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	304,220	2,075,206	2,379,426	0.066198	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	342,277	5,146,105	5,488,382	0.243616	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,630,787	34,370,775	38,001,562	0.205257	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0			88.00
88.01	08801	RURAL HEALTH CLINIC II	0	3,144,872	3,144,872			88.01
88.02	08802	RURAL HEALTH CLINIC III	0	9,982,731	9,982,731			88.02
90.00	09000	CLINIC	6,884	961,263	968,147	0.185241	0.000000	90.00
90.01	09001	SENIOR CARE	239	2,175,627	2,175,866	0.676478	0.000000	90.01
91.00	09100	EMERGENCY	1,217,713	35,375,478	36,593,191	0.147360	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	24,527	2,553,831	2,578,358	0.827841	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	22,822,930	179,696,344	202,519,274			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	22,822,930	179,696,344	202,519,274			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1310 | Period: From 01/01/2022 To 12/31/2022 | Worksheet C Part I Date/Time Prepared: 5/26/2023 3:09 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
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
51.00	05100	RECOVERY ROOM	0.000000		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
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 PATIENT	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC			88.00
88.01	08801	RURAL HEALTH CLINIC II			88.01
88.02	08802	RURAL HEALTH CLINIC III			88.02
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	SENIOR CARE	0.000000		90.01
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
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: 15-1310 | Period: From 01/01/2022 To 12/31/2022 | Worksheet C Part I Date/Time Prepared: 5/26/2023 3:09 pm

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,595,921		6,595,921	0	6,595,921	30.00
43.00	04300	NURSERY	243,679		243,679	0	243,679	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,193,468		4,193,468	0	4,193,468	50.00
51.00	05100	RECOVERY ROOM	0		0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	952,574		952,574	0	952,574	52.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,637,071		4,637,071	0	4,637,071	54.00
60.00	06000	LABORATORY	3,766,728		3,766,728	0	3,766,728	60.00
66.00	06600	PHYSICAL THERAPY	1,948,288	0	1,948,288	0	1,948,288	66.00
67.00	06700	OCCUPATIONAL THERAPY	393,830	0	393,830	0	393,830	67.00
68.00	06800	SPEECH PATHOLOGY	174,356	0	174,356	0	174,356	68.00
69.00	06900	ELECTROCARDIOLOGY	1,948,654		1,948,654	0	1,948,654	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	157,513		157,513	0	157,513	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,337,059		1,337,059	0	1,337,059	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,800,076		7,800,076	0	7,800,076	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0		0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	4,238,855		4,238,855	0	4,238,855	88.01
88.02	08802	RURAL HEALTH CLINIC III	11,055,910		11,055,910	0	11,055,910	88.02
90.00	09000	CLINIC	179,341		179,341	0	179,341	90.00
90.01	09001	SENIOR CARE	1,471,926		1,471,926	0	1,471,926	90.01
91.00	09100	EMERGENCY	5,392,371		5,392,371	0	5,392,371	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,134,471		2,134,471		2,134,471	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	700		700	0	700	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	58,622,791	0	58,622,791	0	58,622,791	200.00
201.00		Less Observation Beds	2,134,471		2,134,471		2,134,471	201.00
202.00		Total (see instructions)	56,488,320	0	56,488,320	0	56,488,320	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1310 | Period: From 01/01/2022 To 12/31/2022 | Worksheet C Part I Date/Time Prepared: 5/26/2023 3:09 pm

Title XIX | Hospital | PPS

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,248,437		6,248,437			30.00
43.00	04300	NURSERY	236,211		236,211			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,517,730	13,434,883	15,952,613	0.262870	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	801,801	82,417	884,218	1.077307	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,641,703	33,131,884	34,773,587	0.133350	0.000000	54.00
60.00	06000	LABORATORY	2,852,510	25,012,183	27,864,693	0.135179	0.000000	60.00
66.00	06600	PHYSICAL THERAPY	365,443	4,920,959	5,286,402	0.368547	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	269,415	499,377	768,792	0.512271	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	94,290	303,135	397,425	0.438714	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	2,268,743	6,525,618	8,794,361	0.221580	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	304,220	2,075,206	2,379,426	0.066198	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	342,277	5,146,105	5,488,382	0.243616	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,630,787	34,370,775	38,001,562	0.205257	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0.000000	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	3,144,872	3,144,872	1.347862	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	9,982,731	9,982,731	1.107504	0.000000	88.02
90.00	09000	CLINIC	6,884	961,263	968,147	0.185241	0.000000	90.00
90.01	09001	SENIOR CARE	239	2,175,627	2,175,866	0.676478	0.000000	90.01
91.00	09100	EMERGENCY	1,217,713	35,375,478	36,593,191	0.147360	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	24,527	2,553,831	2,578,358	0.827841	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	22,822,930	179,696,344	202,519,274			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	22,822,930	179,696,344	202,519,274			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1310 | Period: From 01/01/2022 To 12/31/2022 | Worksheet C Part I Date/Time Prepared: 5/26/2023 3:09 pm

Title XIX | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.262870		50.00
51.00	05100	RECOVERY ROOM	0.000000		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.077307		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.133350		54.00
60.00	06000	LABORATORY	0.135179		60.00
66.00	06600	PHYSICAL THERAPY	0.368547		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.512271		67.00
68.00	06800	SPEECH PATHOLOGY	0.438714		68.00
69.00	06900	ELECTROCARDIOLOGY	0.221580		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.066198		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.243616		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.205257		73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
88.01	08801	RURAL HEALTH CLINIC II	1.347862		88.01
88.02	08802	RURAL HEALTH CLINIC III	1.107504		88.02
90.00	09000	CLINIC	0.185241		90.00
90.01	09001	SENIOR CARE	0.676478		90.01
91.00	09100	EMERGENCY	0.147360		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.827841		92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

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

Provider CCN: 15-1310 | Period: From 01/01/2022 To 12/31/2022 | Worksheet C Part II Date/Time Prepared: 5/26/2023 3:09 pm

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,193,468	865,952	3,327,516	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	952,574	122,457	830,117	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,637,071	816,576	3,820,495	0	0	54.00
60.00	06000	LABORATORY	3,766,728	507,005	3,259,723	0	0	60.00
66.00	06600	PHYSICAL THERAPY	1,948,288	177,973	1,770,315	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	393,830	33,994	359,836	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	174,356	15,326	159,030	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,948,654	356,776	1,591,878	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	157,513	10,396	147,117	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,337,059	88,243	1,248,816	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,800,076	740,067	7,060,009	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	17,505	-17,505	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	4,238,855	347,001	3,891,854	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	11,055,910	1,126,711	9,929,199	0	0	88.02
90.00	09000	CLINIC	179,341	23,254	156,087	0	0	90.00
90.01	09001	SENIOR CARE	1,471,926	270,707	1,201,219	0	0	90.01
91.00	09100	EMERGENCY	5,392,371	821,752	4,570,619	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,134,471	378,512	1,755,959	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	700	46	654	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (sum of lines 50 thru 199)	51,783,191	6,720,253	45,062,938	0	0	200.00
201.00		Less Observation Beds	2,134,471	378,512	1,755,959	0	0	201.00
202.00		Total (line 200 minus line 201)	49,648,720	6,341,741	43,306,979	0	0	202.00

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

Provider CCN: 15-1310 | Period: From 01/01/2022 To 12/31/2022 | Worksheet C Part II | Date/Time Prepared: 5/26/2023 3:09 pm

Title XIX | Hospital | PPS

		Cost Center Description	Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)		
			6.00	7.00	8.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	4,193,468	15,952,613	0.262870		50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	952,574	884,218	1.077307		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,637,071	34,773,587	0.133350		54.00
60.00	06000	LABORATORY	3,766,728	27,864,693	0.135179		60.00
66.00	06600	PHYSICAL THERAPY	1,948,288	5,286,402	0.368547		66.00
67.00	06700	OCCUPATIONAL THERAPY	393,830	768,792	0.512271		67.00
68.00	06800	SPEECH PATHOLOGY	174,356	397,425	0.438714		68.00
69.00	06900	ELECTROCARDIOLOGY	1,948,654	8,794,361	0.221580		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	157,513	2,379,426	0.066198		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,337,059	5,488,382	0.243616		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,800,076	38,001,562	0.205257		73.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000		88.00
88.01	08801	RURAL HEALTH CLINIC II	4,238,855	3,144,872	1.347862		88.01
88.02	08802	RURAL HEALTH CLINIC III	11,055,910	9,982,731	1.107504		88.02
90.00	09000	CLINIC	179,341	968,147	0.185241		90.00
90.01	09001	SENIOR CARE	1,471,926	2,175,866	0.676478		90.01
91.00	09100	EMERGENCY	5,392,371	36,593,191	0.147360		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,134,471	2,578,358	0.827841		92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	700	0	0.000000		95.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (sum of lines 50 thru 199)	51,783,191	196,034,626			200.00
201.00		Less Observation Beds	2,134,471	0			201.00
202.00		Total (line 200 minus line 201)	49,648,720	196,034,626			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-1310 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part II Date/Time Prepared: 5/26/2023 3:09 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	865,952	15,952,613	0.054283	480,184	26,066	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	122,457	884,218	0.138492	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	816,576	34,773,587	0.023483	342,515	8,043	54.00
60.00	06000	LABORATORY	507,005	27,864,693	0.018195	673,425	12,253	60.00
66.00	06600	PHYSICAL THERAPY	177,973	5,286,402	0.033666	126,703	4,266	66.00
67.00	06700	OCCUPATIONAL THERAPY	33,994	768,792	0.044217	80,308	3,551	67.00
68.00	06800	SPEECH PATHOLOGY	15,326	397,425	0.038563	32,079	1,237	68.00
69.00	06900	ELECTROCARDIOLOGY	356,776	8,794,361	0.040569	588,729	23,884	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	10,396	2,379,426	0.004369	120,649	527	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	88,243	5,488,382	0.016078	181,585	2,920	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	740,067	38,001,562	0.019475	873,712	17,016	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	17,505	0	0.000000	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	347,001	3,144,872	0.110339	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	1,126,711	9,982,731	0.112866	0	0	88.02
90.00	09000	CLINIC	23,254	968,147	0.024019	2,727	65	90.00
90.01	09001	SENIOR CARE	270,707	2,175,866	0.124413	0	0	90.01
91.00	09100	EMERGENCY	821,752	36,593,191	0.022456	3,117	70	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	378,512	2,578,358	0.146804	19,516	2,865	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	6,720,207	196,034,626		3,525,249	102,763	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1310 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part IV | Date/Time Prepared: 5/26/2023 3:09 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
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 PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	SENIOR CARE	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1310 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part IV Date/Time Prepared: 5/26/2023 3:09 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	15,952,613	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	884,218	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	34,773,587	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	27,864,693	0.000000	60.00
66.00	06600	PHYSICAL THERAPY	0	0	0	5,286,402	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	768,792	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	397,425	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	8,794,361	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	2,379,426	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	5,488,382	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	38,001,562	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	3,144,872	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	9,982,731	0.000000	88.02
90.00	09000	CLINIC	0	0	0	968,147	0.000000	90.00
90.01	09001	SENIOR CARE	0	0	0	2,175,866	0.000000	90.01
91.00	09100	EMERGENCY	0	0	0	36,593,191	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	2,578,358	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	196,034,626		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1310 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part IV | Date/Time Prepared: 5/26/2023 3:09 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	480,184	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	342,515	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	673,425	0	0	0	60.00
66.00	06600	PHYSICAL THERAPY	0.000000	126,703	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	80,308	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	32,079	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	588,729	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	120,649	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	181,585	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	873,712	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000	0	0	0	0	88.02
90.00	09000	CLINIC	0.000000	2,727	0	0	0	90.00
90.01	09001	SENIOR CARE	0.000000	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.000000	3,117	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	19,516	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		3,525,249	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1310 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part V Date/Time Prepared: 5/26/2023 3:09 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	0.262870	0	2,416,690	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.077307	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.133350	0	7,172,171	0	0	54.00
60.00	06000	LABORATORY	0.135179	0	5,072,446	0	0	60.00
66.00	06600	PHYSICAL THERAPY	0.368547	0	1,301,372	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.512271	0	132,902	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.438714	0	65,740	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.221580	0	1,694,780	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.066198	0	310,024	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.243616	0	717,627	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.205257	0	12,817,805	74	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC						88.00
88.01	08801	RURAL HEALTH CLINIC II						88.01
88.02	08802	RURAL HEALTH CLINIC III						88.02
90.00	09000	CLINIC	0.185241	0	258,030	0	0	90.00
90.01	09001	SENIOR CARE	0.676478	0	238,127	0	0	90.01
91.00	09100	EMERGENCY	0.147360	0	6,945,707	13,150	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.827841	0	563,282	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000		0			95.00
200.00		Subtotal (see instructions)		0	39,706,703	13,224	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	39,706,703	13,224	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1310 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part V Date/Time Prepared: 5/26/2023 3:09 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	635,275	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	956,409	0		54.00
60.00	06000	LABORATORY	685,688	0		60.00
66.00	06600	PHYSICAL THERAPY	479,617	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	68,082	0		67.00
68.00	06800	SPEECH PATHOLOGY	28,841	0		68.00
69.00	06900	ELECTROCARDIOLOGY	375,529	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	20,523	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	174,825	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,630,944	15		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC				88.00
88.01	08801	RURAL HEALTH CLINIC II				88.01
88.02	08802	RURAL HEALTH CLINIC III				88.02
90.00	09000	CLINIC	47,798	0		90.00
90.01	09001	SENIOR CARE	161,088	0		90.01
91.00	09100	EMERGENCY	1,023,519	1,938		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	466,308	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	7,754,446	1,953		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	7,754,446	1,953		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-1310 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part I Date/Time Prepared: 5/26/2023 3:09 pm

Title XIX | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,169,677	23,650	1,146,027	4,481	255.75	30.00
43.00	NURSERY	26,276		26,276	108	243.30	43.00
200.00	Total (lines 30 through 199)	1,195,953		1,172,303	4,589		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6.00	7.00				
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	58	14,834				30.00
43.00	NURSERY	4	973				43.00
200.00	Total (lines 30 through 199)	62	15,807				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-1310 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part II Date/Time Prepared: 5/26/2023 3:09 pm

Title XIX | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	865,952	15,952,613	0.054283	36,236	1,967	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	122,457	884,218	0.138492	414	57	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	816,576	34,773,587	0.023483	60,523	1,421	54.00
60.00	06000	LABORATORY	507,005	27,864,693	0.018195	116,201	2,114	60.00
66.00	06600	PHYSICAL THERAPY	177,973	5,286,402	0.033666	4,820	162	66.00
67.00	06700	OCCUPATIONAL THERAPY	33,994	768,792	0.044217	2,798	124	67.00
68.00	06800	SPEECH PATHOLOGY	15,326	397,425	0.038563	2,364	91	68.00
69.00	06900	ELECTROCARDIOLOGY	356,776	8,794,361	0.040569	47,973	1,946	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	10,396	2,379,426	0.004369	6,302	28	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	88,243	5,488,382	0.016078	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	740,067	38,001,562	0.019475	72,120	1,405	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	17,505	0	0.000000	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	347,001	3,144,872	0.110339	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	1,126,711	9,982,731	0.112866	0	0	88.02
90.00	09000	CLINIC	23,254	968,147	0.024019	456	11	90.00
90.01	09001	SENIOR CARE	270,707	2,175,866	0.124413	0	0	90.01
91.00	09100	EMERGENCY	821,752	36,593,191	0.022456	101,397	2,277	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	378,512	2,578,358	0.146804	5,011	736	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	6,720,207	196,034,626		456,615	12,339	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1310 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part III Date/Time Prepared: 5/26/2023 3:09 pm

Title XIX | Hospital | PPS

		Cost Center Description	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	4,481	0.00	58	30.00
43.00	04300	NURSERY		0	108	0.00	4	43.00
200.00		Total (lines 30 through 199)		0	4,589		62	200.00

		Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
			9.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	0	30.00
43.00	04300	NURSERY	0	43.00
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1310 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part IV | Date/Time Prepared: 5/26/2023 3:09 pm

Title XIX | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
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 PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	SENIOR CARE	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1310 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part IV | Date/Time Prepared: 5/26/2023 3:09 pm

Title XIX | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	15,952,613	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	884,218	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	34,773,587	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	27,864,693	0.000000	60.00
66.00	06600	PHYSICAL THERAPY	0	0	0	5,286,402	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	768,792	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	397,425	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	8,794,361	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	2,379,426	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	5,488,382	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	38,001,562	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	3,144,872	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	9,982,731	0.000000	88.02
90.00	09000	CLINIC	0	0	0	968,147	0.000000	90.00
90.01	09001	SENIOR CARE	0	0	0	2,175,866	0.000000	90.01
91.00	09100	EMERGENCY	0	0	0	36,593,191	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	2,578,358	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	196,034,626		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1310 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part IV | Date/Time Prepared: 5/26/2023 3:09 pm

Title XIX | Hospital | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	36,236	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	414	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	60,523	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	116,201	0	0	0	60.00
66.00	06600	PHYSICAL THERAPY	0.000000	4,820	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	2,798	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	2,364	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	47,973	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	6,302	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	72,120	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000	0	0	0	0	88.02
90.00	09000	CLINIC	0.000000	456	0	0	0	90.00
90.01	09001	SENIOR CARE	0.000000	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.000000	101,397	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	5,011	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		456,615	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1310 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part V Date/Time Prepared: 5/26/2023 3:09 pm

Title XIX | Hospital | PPS

		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	0.262870	0	0	201,010	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.077307	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.133350	0	0	333,095	0	54.00
60.00	06000	LABORATORY	0.135179	0	0	340,271	0	60.00
66.00	06600	PHYSICAL THERAPY	0.368547	0	0	13,942	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.512271	0	0	2,606	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.438714	0	0	12,991	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.221580	0	0	62,960	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.066198	0	0	28,578	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.243616	0	0	48,996	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.205257	0	0	88,708	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC						88.00
88.01	08801	RURAL HEALTH CLINIC II						88.01
88.02	08802	RURAL HEALTH CLINIC III						88.02
90.00	09000	CLINIC	0.185241	0	0	6,319	0	90.00
90.01	09001	SENIOR CARE	0.676478	0	0	89,249	0	90.01
91.00	09100	EMERGENCY	0.147360	0	0	675,092	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.827841	0	0	51,124	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000	0	0			95.00
200.00		Subtotal (see instructions)		0	0	1,954,941	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	0	1,954,941	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1310 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part V Date/Time Prepared: 5/26/2023 3:09 pm

Title XIX | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	52,839		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	44,418		54.00
60.00	06000	LABORATORY	0	45,997		60.00
66.00	06600	PHYSICAL THERAPY	0	5,138		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,335		67.00
68.00	06800	SPEECH PATHOLOGY	0	5,699		68.00
69.00	06900	ELECTROCARDIOLOGY	0	13,951		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,892		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	11,936		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	18,208		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC				88.00
88.01	08801	RURAL HEALTH CLINIC II				88.01
88.02	08802	RURAL HEALTH CLINIC III				88.02
90.00	09000	CLINIC	0	1,171		90.00
90.01	09001	SENIOR CARE	0	60,375		90.01
91.00	09100	EMERGENCY	0	99,482		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	42,323		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	0	404,764		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	404,764		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1310 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-1 | Date/Time Prepared: 5/26/2023 3:09 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)	4,590	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	4,481	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)	3,001	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	89	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	20	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)	927	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)	31	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)	6,595,921	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)	5,009	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)	133,366	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	6,462,555	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)	6,462,555	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)	1,442.21	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,336,929	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	1,336,929	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1310 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-1 | Date/Time Prepared: 5/26/2023 3:09 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						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)	743,973	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)	2,080,902	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)	44,709	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	44,709	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)	1,480	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,442.21	88.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-1310	Period: From 01/01/2022 To 12/31/2022	Worksheet D-1 Date/Time Prepared: 5/26/2023 3:09 pm
	Title XVIII	Hospital	Cost

	Cost Center Description		
		1.00	
89.00	Observation bed cost (line 87 x line 88) (see instructions)	2,134,471	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	1,169,677	6,595,921	0.177333	2,134,471	378,512	90.00
91.00	Nursing Program cost	0	6,595,921	0.000000	2,134,471	0	91.00
92.00	Allied health cost	0	6,595,921	0.000000	2,134,471	0	92.00
93.00	All other Medical Education	0	6,595,921	0.000000	2,134,471	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-1310	Period: From 01/01/2022 To 12/31/2022	Worksheet D-1 Date/Time Prepared: 5/26/2023 3:09 pm
	Title XIX	Hospital	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	4,590	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	4,481	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)	3,001	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	89	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	20	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)	58	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)	108	15.00
16.00	Nursery days (title V or XIX only)	4	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)	6,595,921	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)	5,009	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)	133,366	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	6,462,555	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)	6,462,555	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)	1,442.21	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	83,648	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)	83,648	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1310 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-1 | Date/Time Prepared: 5/26/2023 3:09 pm

Title XIX | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	243,679	108	2,256.29	4	9,025	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	83,020	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)	175,693	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)	15,807	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	12,339	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	28,146	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	147,547	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)	1,480	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,442.21	88.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-1310	Period: From 01/01/2022 To 12/31/2022	Worksheet D-1 Date/Time Prepared: 5/26/2023 3:09 pm
	Title XIX	Hospital	PPS

	Cost Center Description		
		1.00	
89.00	Observation bed cost (line 87 x line 88) (see instructions)	2,134,471	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	1,169,677	6,595,921	0.177333	2,134,471	378,512	90.00
91.00	Nursing Program cost	0	6,595,921	0.000000	2,134,471	0	91.00
92.00	Allied health cost	0	6,595,921	0.000000	2,134,471	0	92.00
93.00	All other Medical Education	0	6,595,921	0.000000	2,134,471	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1310 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-3 | Date/Time Prepared: 5/26/2023 3:09 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		1,846,147		30.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.262870	480,184	126,226	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.077307	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.133350	342,515	45,674	54.00
60.00	06000	LABORATORY	0.135179	673,425	91,033	60.00
66.00	06600	PHYSICAL THERAPY	0.368547	126,703	46,696	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.512271	80,308	41,139	67.00
68.00	06800	SPEECH PATHOLOGY	0.438714	32,079	14,074	68.00
69.00	06900	ELECTROCARDIOLOGY	0.221580	588,729	130,451	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.066198	120,649	7,987	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.243616	181,585	44,237	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.205257	873,712	179,336	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000		0	88.02
90.00	09000	CLINIC	0.185241	2,727	505	90.00
90.01	09001	SENIOR CARE	0.676478	0	0	90.01
91.00	09100	EMERGENCY	0.147360	3,117	459	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.827841	19,516	16,156	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		3,525,249	743,973	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		3,525,249		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1310 | Component CCN: 15-Z310 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-3 | Date/Time Prepared: 5/26/2023 3:09 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
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.262870	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.077307	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.133350	308	41	54.00
60.00	06000	LABORATORY	0.135179	6,973	943	60.00
66.00	06600	PHYSICAL THERAPY	0.368547	13,349	4,920	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.512271	12,416	6,360	67.00
68.00	06800	SPEECH PATHOLOGY	0.438714	2,202	966	68.00
69.00	06900	ELECTROCARDIOLOGY	0.221580	2,460	545	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.066198	3,411	226	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.243616	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.205257	3,191	655	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000		0	88.02
90.00	09000	CLINIC	0.185241	0	0	90.00
90.01	09001	SENIOR CARE	0.676478	0	0	90.01
91.00	09100	EMERGENCY	0.147360	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.827841	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		44,310	14,656	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)		44,310		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1310 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-3 | Date/Time Prepared: 5/26/2023 3:09 pm

Title XIX | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		114,875		30.00
43.00	04300	NURSERY		7,204		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.262870	36,236	9,525	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.077307	414	446	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.133350	60,523	8,071	54.00
60.00	06000	LABORATORY	0.135179	116,201	15,708	60.00
66.00	06600	PHYSICAL THERAPY	0.368547	4,820	1,776	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.512271	2,798	1,433	67.00
68.00	06800	SPEECH PATHOLOGY	0.438714	2,364	1,037	68.00
69.00	06900	ELECTROCARDIOLOGY	0.221580	47,973	10,630	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.066198	6,302	417	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.243616	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.205257	72,120	14,803	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	1.347862	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	1.107504	0	0	88.02
90.00	09000	CLINIC	0.185241	456	84	90.00
90.01	09001	SENIOR CARE	0.676478	0	0	90.01
91.00	09100	EMERGENCY	0.147360	101,397	14,942	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.827841	5,011	4,148	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		456,615	83,020	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)		456,615		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1310	Period: From 01/01/2022 To 12/31/2022	Worksheet E Part B Date/Time Prepared: 5/26/2023 3:09 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	7,756,399	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)	7,756,399	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)	7,833,963	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)	77,192	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	6,880,586	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)	876,185	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)	876,185	30.00
31.00	Primary payer payments	391	31.00
32.00	Subtotal (line 30 minus line 31)	875,794	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)	815,690	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	530,199	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	621,274	36.00
37.00	Subtotal (see instructions)	1,405,993	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)	1,405,993	40.00
40.01	Sequestration adjustment (see instructions)	17,716	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	2,248,170	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)	-859,893	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: 15-1310	Period: From 01/01/2022 To 12/31/2022	Worksheet E Part B Date/Time Prepared: 5/26/2023 3:09 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: 15-1310 | Period: From 01/01/2022 To 12/31/2022 | Worksheet E-1 Part I Date/Time Prepared: 5/26/2023 3:09 pm

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,447,853		2,248,170	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,447,853		2,248,170	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		327,120		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		859,893	6.02
7.00	Total Medicare program liability (see instructions)		1,774,973		1,388,277	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: 15-1310 | Component CCN: 15-Z310 | Period: From 01/01/2022 To 12/31/2022 | Worksheet E-1 Part I | Date/Time Prepared: 5/26/2023 3:09 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		50,935		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)		50,935		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		8,268		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		59,203		0	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-1310	Period: From 01/01/2022 To 12/31/2022	Worksheet E-1 Part II Date/Time Prepared: 5/26/2023 3:09 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: 15-1310 | Component CCN: 15-Z310 | Period: From 01/01/2022 To 12/31/2022 | Worksheet E-2 | Date/Time Prepared: 5/26/2023 3:09 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)	45,156	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)	14,803	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	31	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)	59,959	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	59,959	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)	59,959	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	0	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (see instructions)	59,959	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)	59,959	0	19.00
19.01	Sequestration adjustment (see instructions)	756	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	50,935	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)	8,268	0	22.00
22.01	Balance due provider/program-PARHM or CHART (see instructions)			22.01
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	23.00
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
	Cost Reimbursement			
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))			201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))			202.00
203.00	Total (sum of lines 201 and 202)			203.00
204.00	Medicare swing-bed SNF discharges (see instructions)			204.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
205.00	Medicare swing-bed SNF target amount			205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)			206.00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)			208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
	Comparision of PPS versus Cost Reimbursement			
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)			215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1310	Period: From 01/01/2022 To 12/31/2022	Worksheet E-3 Part V Date/Time Prepared: 5/26/2023 3:09 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	2,080,902	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)	2,080,902	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	2,101,711	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)	2,101,711	19.00
20.00	Deductibles (exclude professional component)	315,724	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	1,785,987	22.00
23.00	Coinsurance	5,057	23.00
24.00	Subtotal (line 22 minus line 23)	1,780,930	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	25,681	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	16,693	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	11,792	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	1,797,623	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29.98	Recovery of accelerated depreciation.	0	29.98
29.99	Demonstration payment adjustment amount before sequestration	0	29.99
30.00	Subtotal (see instructions)	1,797,623	30.00
30.01	Sequestration adjustment (see instructions)	22,650	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
30.03	Sequestration adjustment-PARHM or CHART		30.03
31.00	Interim payments	1,447,853	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)	327,120	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

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 15-1310 | Period: From 01/01/2022 To 12/31/2022 | Worksheet G | Date/Time Prepared: 5/26/2023 3:09 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	1,350	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	23,859,020	0	0	0	4.00
5.00	Other receivable	709	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-14,709,521	0	0	0	6.00
7.00	Inventory	1,034,532	0	0	0	7.00
8.00	Prepaid expenses	21,726	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	-22,201,486	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	-11,993,670	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	1,208,757	0	0	0	12.00
13.00	Land improvements	1,875,057	0	0	0	13.00
14.00	Accumulated depreciation	-931,449	0	0	0	14.00
15.00	Buildings	31,518,742	0	0	0	15.00
16.00	Accumulated depreciation	-7,122,819	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	2,180,492	0	0	0	19.00
20.00	Accumulated depreciation	-698,476	0	0	0	20.00
21.00	Automobiles and trucks	18,500	0	0	0	21.00
22.00	Accumulated depreciation	-18,500	0	0	0	22.00
23.00	Major movable equipment	14,000,454	0	0	0	23.00
24.00	Accumulated depreciation	-9,239,516	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)	32,791,242	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	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	0	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	20,797,572	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1,538,725	0	0	0	37.00
38.00	Salaries, wages, and fees payable	636,352	0	0	0	38.00
39.00	Payroll taxes payable	0	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	7,301,222	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	9,476,299	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	20,344,945	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	20,344,945	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	29,821,244	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	-9,023,672				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)	-9,023,672	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	20,797,572	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-1310 | Period: From 01/01/2022 To 12/31/2022 | Worksheet G-1 | Date/Time Prepared: 5/26/2023 3:09 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		-8,549,279		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-98,029				2.00
3.00	Total (sum of line 1 and line 2)		-8,647,308		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)		-8,647,308		0		11.00
12.00	ADJUSTMENT	376,364		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)		376,364		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		-9,023,672		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	ADJUSTMENT		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: 15-1310 | Period: From 01/01/2022 To 12/31/2022 | Worksheet G-2 Parts I & II Date/Time Prepared: 5/26/2023 3:09 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	8,420,963		8,420,963	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)	8,420,963		8,420,963	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	8,420,963		8,420,963	17.00
18.00	Ancillary services	13,501,542	124,832,787	138,334,329	18.00
19.00	Outpatient services	1,409,842	41,226,537	42,636,379	19.00
20.00	RURAL HEALTH CLINIC	0	-1,417	-1,417	20.00
20.01	RURAL HEALTH CLINIC II	0	3,144,872	3,144,872	20.01
20.02	RURAL HEALTH CLINIC III	0	9,982,731	9,982,731	20.02
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	0	0	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	Other Patient Service Revenue	152,339	375,215	527,554	27.00
27.01	Other Patient Service Revenue - NRCCs	-8,532	1,153,923	1,145,391	27.01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	23,476,154	180,714,648	204,190,802	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		61,333,934		29.00
30.00	NONALLOWABLE HOME OFFICE INTEREST	539,038			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)		539,038		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)		61,872,972		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-1310 | Period: From 01/01/2022 To 12/31/2022 | Worksheet G-3 | Date/Time Prepared: 5/26/2023 3:09 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	204,190,802	1.00
2.00	Less contractual allowances and discounts on patients' accounts	143,007,542	2.00
3.00	Net patient revenues (line 1 minus line 2)	61,183,260	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	61,872,972	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-689,712	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	6,286	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	330,691	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	46,136	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	6,457	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	126,394	22.00
23.00	Governmental appropriations	143,899	23.00
24.00	OTHER (SPECIFY)	0	24.00
24.01	Misc Revenue	-70,567	24.01
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	589,296	25.00
26.00	Total (line 5 plus line 25)	-100,416	26.00
27.00	LOSS ON DISPOSAL OF ASSETS	-2,387	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	-2,387	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-98,029	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1310 | Component CCN: 15-8541 | Period: From 01/01/2022 To 12/31/2022 | Worksheet M-1 | Date/Time Prepared: 5/26/2023 3:09 pm

RHC II

		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	489,044	102,168	591,212	0	591,212	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	217,312	45,399	262,711	0	262,711	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	336,570	70,314	406,884	0	406,884	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	251,009	52,439	303,448	0	303,448	9.00
10.00	Subtotal (sum of lines 1 through 9)	1,293,935	270,320	1,564,255	0	1,564,255	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	233,018	233,018	0	233,018	15.00
16.00	Transportation (Health Care Staff)	0	4,656	4,656	0	4,656	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	1,324	1,324	0	1,324	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	238,998	238,998	0	238,998	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,293,935	509,318	1,803,253	0	1,803,253	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	7,219	1,508	8,727	0	8,727	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)	7,219	1,508	8,727	0	8,727	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	151,590	151,590	0	151,590	29.00
30.00	Administrative Costs	52,935	511,941	564,876	0	564,876	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	52,935	663,531	716,466	0	716,466	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,354,089	1,174,357	2,528,446	0	2,528,446	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1310 | Component CCN: 15-8541 | Period: From 01/01/2022 To 12/31/2022 | Worksheet M-1 | Date/Time Prepared: 5/26/2023 3:09 pm

RHC II

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	591,212		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	262,711		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	406,884		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	303,448		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	1,564,255		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	233,018		15.00
16.00	Transportation (Health Care Staff)	0	4,656		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	1,324		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	238,998		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	1,803,253		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	8,727		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	8,727		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	151,590		29.00
30.00	Administrative Costs	-978	563,898		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-978	715,488		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-978	2,527,468		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1310 | Component CCN: 15-8542 | Period: From 01/01/2022 To 12/31/2022 | Worksheet M-1 | Date/Time Prepared: 5/26/2023 3:09 pm

RHC III

		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	669,267	114,217	783,484	0	783,484	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	719,058	328,107	1,047,165	0	1,047,165	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	753,687	128,625	882,312	0	882,312	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	394,207	308,793	703,000	0	703,000	9.00
10.00	Subtotal (sum of lines 1 through 9)	2,536,219	879,742	3,415,961	0	3,415,961	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	597,249	597,249	0	597,249	15.00
16.00	Transportation (Health Care Staff)	0	7,728	7,728	0	7,728	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	1,829	1,829	0	1,829	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	606,806	606,806	0	606,806	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	2,536,219	1,486,548	4,022,767	0	4,022,767	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	11,703	1,997	13,700	0	13,700	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)	11,703	1,997	13,700	0	13,700	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	433,245	433,245	0	433,245	29.00
30.00	Administrative Costs	804,356	1,377,467	2,181,823	0	2,181,823	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	804,356	1,810,712	2,615,068	0	2,615,068	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	3,352,278	3,299,257	6,651,535	0	6,651,535	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS | Provider CCN: 15-1310 | Component CCN: 15-8542 | Period: From 01/01/2022 To 12/31/2022 | Worksheet M-1 | Date/Time Prepared: 5/26/2023 3:09 pm

RHC III

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	783,484		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	1,047,165		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	882,312		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	703,000		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	3,415,961		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	597,249		15.00
16.00	Transportation (Health Care Staff)	0	7,728		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	1,829		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	606,806		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	4,022,767		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	13,700		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	13,700		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	433,245		29.00
30.00	Administrative Costs	-483	2,181,340		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-483	2,614,585		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-483	6,651,052		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-1310 | Component CCN: 15-8541 | Period: From 01/01/2022 To 12/31/2022 | Worksheet M-2 | Date/Time Prepared: 5/26/2023 3:09 pm

RHC II

		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	1.75	7,989	4,200	7,350		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	1.59	4,584	2,100	3,339		3.00
4.00	Subtotal (sum of lines 1 through 3)	3.34	12,573		10,689	12,573	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)	3.34	12,573			12,573	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)					1,803,253	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					8,727	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					1,811,980	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.995184	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					715,488	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					1,711,387	15.00
16.00	Total overhead (sum of lines 14 and 15)					2,426,875	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					2,426,875	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					2,415,187	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					4,218,440	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-1310 | Component CCN: 15-8542 | Period: From 01/01/2022 To 12/31/2022 | Worksheet M-2 | Date/Time Prepared: 5/26/2023 3:09 pm

RHC III

		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	1.86	9,644	4,200	7,812		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	4.50	33,531	2,100	9,450		3.00
4.00	Subtotal (sum of lines 1 through 3)	6.36	43,175		17,262	43,175	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)	6.36	43,175			43,175	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)					4,022,767	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					13,700	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					4,036,467	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.996606	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					2,614,585	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					4,404,858	15.00
16.00	Total overhead (sum of lines 14 and 15)					7,019,443	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					7,019,443	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					6,995,619	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					11,018,386	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 15-1310 Component CCN: 15-8541	Period: From 01/01/2022 To 12/31/2022	Worksheet M-3 Date/Time Prepared: 5/26/2023 3:09 pm
	Title XVIII	RHC II	

		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)	4,218,440	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)	310,979	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)	3,907,461	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)	12,573	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)	12,573	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)	310.78	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	244.94	8.00
9.00	Rate for Program covered visits (see instructions)	0.00	244.94	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	2,170	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	531,520	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	531,520	16.00
16.01	Total program charges (see instructions)(from contractor's records)		540,670	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		47,137	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		46,340	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.)		347,565	16.04
16.05	Total program cost (see instructions)	0	393,905	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		50,724	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		88,531	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		393,905	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		52,079	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		445,984	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)		445,984	26.00
26.01	Sequestration adjustment (see instructions)		5,619	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		382,135	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)		58,230	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: 15-1310 Component CCN: 15-8542	Period: From 01/01/2022 To 12/31/2022	Worksheet M-3 Date/Time Prepared: 5/26/2023 3:09 pm
	Title XVIII	RHC III	

			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)		11,018,386	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)		844,715	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)		10,173,671	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		43,175	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)		43,175	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		235.64	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	213.28	8.00
9.00	Rate for Program covered visits (see instructions)	0.00	213.28	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	4,491	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	957,840	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	957,840	16.00
16.01	Total program charges (see instructions)(from contractor's records)		1,023,128	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		84,344	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		78,961	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.)		609,718	16.04
16.05	Total program cost (see instructions)	0	688,679	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		116,732	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		164,412	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		688,679	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		117,310	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		805,989	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)		805,989	26.00
26.01	Sequestration adjustment (see instructions)		10,155	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		671,096	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)		124,738	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: 15-1310 | Component CCN: 15-8541 | Period: From 01/01/2022 To 12/31/2022 | Worksheet M-4 | Date/Time Prepared: 5/26/2023 3:09 pm

Title XVIII | RHC II

		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)	1,564,255	1,564,255	1,564,255	1,564,255	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.001410	0.002660	0.000019	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	2,206	4,161	30	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	88,733	34,375	3,429	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	90,939	38,536	3,459	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	1,803,253	1,803,253	1,803,253	1,803,253	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	2,415,187	2,415,187	2,415,187	2,415,187	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.050431	0.021370	0.001918	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	121,800	51,613	4,632	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	212,739	90,149	8,091	0	10.00
11.00	Total number of injections/infusions (from your records)	450	849	6	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	472.75	106.18	1,348.50	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	74	161	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)	34,984	17,095	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)		310,979	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)		52,079	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 15-1310 | Component CCN: 15-8542 | Period: From 01/01/2022 To 12/31/2022 | Worksheet M-4 | Date/Time Prepared: 5/26/2023 3:09 pm

Title XVIII | RHC III

		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	3,415,961	3,415,961	3,415,961	3,415,961	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.001907	0.002793	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	6,514	9,541	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	229,241	63,107	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	235,755	72,648	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	4,022,767	4,022,767	4,022,767	4,022,767	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	6,995,619	6,995,619	6,995,619	6,995,619	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.058605	0.018059	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	409,978	126,334	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	645,733	198,982	0	0	10.00
11.00	Total number of injections/infusions (from your records)	1,152	1,687	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	560.53	117.95	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	143	315	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)	80,156	37,154	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)		844,715	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)		117,310	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 15-1310 Component CCN: 15-8541	Period: From 01/01/2022 To 12/31/2022	Worksheet M-5 Date/Time Prepared: 5/26/2023 3:09 pm
		RHC II	

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		382,135	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)		382,135	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		58,230	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		440,365	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: 15-1310 Component CCN: 15-8542	Period: From 01/01/2022 To 12/31/2022	Worksheet M-5 Date/Time Prepared: 5/26/2023 3:09 pm
		RHC III	

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		671,096	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)		671,096	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		124,738	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		795,834	7.00

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