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: 15-1322	Period: From 01/01/2022 To 12/31/2022	Worksheet S Parts I-III Date/Time Prepared: 5/23/2023 1:34 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 5/23/2023 Time: 1:34 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 PERRY COUNTY HOSPITAL (15-1322) 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	Randall Russell		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	Randall Russell			2
3	Signatory Title	CHIEF FINANCIAL OFFICER			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	328,451	-268,738	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	303,746	0		0	5.00
6.00	SWING BED - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC - TCC I	0		17,415		0	10.00
10.01	RURAL HEALTH CLINIC II - PCFP	0		3,061		0	10.01
10.02	RURAL HEALTH CLINIC III - 13TH	0		2,535		0	10.02
10.03	RURAL HEALTH CLINIC IV - SPENCER	0		23,887		0	10.03
200.00	TOTAL	0	632,197	-221,840	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1322 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-2 Part I | Date/Time Prepared: 5/23/2023 1:34 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 8885 SR 237	PO Box: X			1.00
2.00	City: TELL CITY	State: IN	Zip Code: 47586	County: PERRY	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	PERRY COUNTY HOSPITAL	151322	99915	1	07/01/2004	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	PERRY COUNTY HOSPITAL SWING	15Z322	99915		07/01/2004	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	TELL CITY CLINIC	158516	99915		05/18/2015	N	O	N	15.00
15.01	Hospital-Based Health Clinic - RHC II	PERRY CO FAMILY PRACTICE	158517	99915		05/19/2015	N	O	N	15.01
15.02	Hospital-Based Health Clinic - RHC III	PERRY CO SURG - 13TH ST	158560	99915		03/24/2021	N	O	N	15.02
15.03	Hospital-Based Health Clinic - RHC IV	SPENCER CO CLINIC	158562	99915		03/24/2021	N	O	N	15.03
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2022	12/31/2022	20.00
21.00	Type of Control (see instructions)	9		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

		1.00	2.00	3.00	
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	2	N		23.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1322	Period: From 01/01/2022 To 12/31/2022	Worksheet S-2 Part I Date/Time Prepared: 5/23/2023 1:34 pm

		V	XVIII	XIX	
		1.00	2.00	3.00	
57.00	For cost reporting periods beginning prior to December 27, 2020, if line 56, column 1, is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.77(e)(1)(iv) and (v), regardless of which month(s) of the cost report the residents were on duty, if the response to line 56 is "Y" for yes, enter "Y" for yes in column 1, do not complete column 2, and complete Worksheet E-4.				57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.				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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1322	Period: From 01/01/2022 To 12/31/2022	Worksheet S-2 Part I Date/Time Prepared: 5/23/2023 1:34 pm

		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

		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	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1322 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-2 Part I | Date/Time Prepared: 5/23/2023 1:34 pm

		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

		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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1322	Period: From 01/01/2022 To 12/31/2022	Worksheet S-2 Part I Date/Time Prepared: 5/23/2023 1:34 pm

		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
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.06
	Rural Providers			
105.00	Does this hospital qualify as a CAH?	Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

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

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

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	284,697	0	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	Y	5.02	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

		1.00	2.00	
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		140.00

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

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

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

		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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1322	Period: From 01/01/2022 To 12/31/2022	Worksheet S-2 Part I Date/Time Prepared: 5/23/2023 1:34 pm

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1322 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-2 Part II | Date/Time Prepared: 5/23/2023 1:34 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	R		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	N		N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	03/30/2023	Y	03/30/2023	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1322 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-2 Part II Date/Time Prepared: 5/23/2023 1:34 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?	N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	N		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	N		40.00

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	CLINT	BRILL	41.00
42.00	Enter the employer/company name of the cost report preparer.	BLUE & CO., LLC		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	5029923500	CBRILL@BLUEANDCO.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-1322	Period: From 01/01/2022 To 12/31/2022	Worksheet S-2 Part II Date/Time Prepared: 5/23/2023 1:34 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.	MANAGER		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: 15-1322 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-3 Part I | Date/Time Prepared: 5/23/2023 1:34 pm

	Component	Worksheet A Line No.	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	25	9,125	44,424.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		25	9,125	44,424.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	0	0	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		25	9,125	44,424.00	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	116.00	0	0			24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC - TCC	88.00				0	26.00
26.01	RURAL HEALTH CLINIC II - PCFP	88.01				0	26.01
26.02	RURAL HEALTH CLINIC III - 13TH	88.02				2	26.02
26.03	RURAL HEALTH CLINIC IV - SPENCER	88.03				0	26.03
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		25				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care	30.00	0	0		0	34.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1322 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-3 Part I | Date/Time Prepared: 5/23/2023 1:34 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)	974	21	1,851			1.00
2.00	HMO and other (see instructions)	286	198				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	824	0	824			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	204			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,798	21	2,879			7.00
8.00	INTENSIVE CARE UNIT	0	0	0			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		0	119			13.00
14.00	Total (see instructions)	1,798	21	2,998	0.00	211.91	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	0	0	0	0.00	0.00	24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC - TCC	2,331	0	8,875	0.00	22.23	26.00
26.01	RURAL HEALTH CLINIC II - PCFP	147	0	2,507	0.00	6.37	26.01
26.02	RURAL HEALTH CLINIC III - 13TH	511	0	5,356	0.00	2.68	26.02
26.03	RURAL HEALTH CLINIC IV - SPENCER	976	0	4,414	0.00	7.30	26.03
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	250.49	27.00
28.00	Observation Bed Days		6	476			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	1	34			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: 15-1322 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-3 Part I Date/Time Prepared: 5/23/2023 1:34 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	237	6	517	1.00
2.00	HMO and other (see instructions)			67	53		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	237	6	517	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	0.00					24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC - TCC	0.00					26.00
26.01	RURAL HEALTH CLINIC II - PCFP	0.00					26.01
26.02	RURAL HEALTH CLINIC III - 13TH	0.00					26.02
26.03	RURAL HEALTH CLINIC IV - SPENCER	0.00					26.03
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: 15-1322 Component CCN: 15-8516	Period: From 01/01/2022 To 12/31/2022	Worksheet S-8 Date/Time Prepared: 5/23/2023 1:34 pm
		RHC I	Cost

					1.00		
	Clinic Address and Identification						
1.00	Street				109 IN-66		1.00
			City		State	ZIP Code	
			1.00		2.00	3.00	
2.00	City, State, ZIP Code, County		TELL CITY		IN	47586	2.00
						1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban					0	3.00
				Grant Award		Date	
				1.00		2.00	
	Source of Federal Funds						
4.00	Community Health Center (Section 330(d), PHS Act)						4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)						5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)						6.00
7.00	Appalachian Regional Commission						7.00
8.00	Look-Alikes						8.00
9.00	OTHER (SPECIFY)						9.00
					1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)				N	0	10.00
		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	CLINIC			07:00	20:00	07:00	11.00
					1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?				N		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.				N	0	13.00
				Provider name		CCN	
				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		PERRY				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	20:00	07:00	20:00	07:00	20:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA	Provider CCN: 15-1322 Component CCN: 15-8516	Period: From 01/01/2022 To 12/31/2022	Worksheet S-8 Date/Time Prepared: 5/23/2023 1:34 pm
		RHC I	Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	07:00	20:00				11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA	Provider CCN: 15-1322 Component CCN: 15-8517	Period: From 01/01/2022 To 12/31/2022	Worksheet S-8 Date/Time Prepared: 5/23/2023 1:34 pm
		RHC II	Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			18485 STATE ROAD 37		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	LEOPOLD		IN	47551	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

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

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

		Provider name	CCN	
		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	PERRY	2.00

		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC	16:00			07:00	16:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA	Provider CCN: 15-1322 Component CCN: 15-8517	Period: From 01/01/2022 To 12/31/2022	Worksheet S-8 Date/Time Prepared: 5/23/2023 1:34 pm
		RHC II	Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	07:00	16:00				11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA	Provider CCN: 15-1322 Component CCN: 15-8560	Period: From 01/01/2022 To 12/31/2022	Worksheet S-8 Date/Time Prepared: 5/23/2023 1:34 pm
		RHC III	Cost

					1.00		
	Clinic Address and Identification						
1.00	Street				148 13TH STREET		1.00
			City		State	ZIP Code	
			1.00		2.00	3.00	
2.00	City, State, ZIP Code, County		TELL CITY		IN	47586	2.00
						1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban					0	3.00
				Grant Award		Date	
				1.00		2.00	
	Source of Federal Funds						
4.00	Community Health Center (Section 330(d), PHS Act)						4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)						5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)						6.00
7.00	Appalachian Regional Commission						7.00
8.00	Look-Alikes						8.00
9.00	OTHER (SPECIFY)						9.00
					1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)				N	0	10.00
		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	CLINIC			08:00	16:00	08:00	11.00
					1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?						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		PERRY				2.00
		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC	16:00	08:00	16:00	08:00	16:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 15-1322 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-8

Component CCN: 15-8560 | Date/Time Prepared: 5/23/2023 1:34 pm

RHC III | Cost

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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

	Provider CCN: 15-1322	Period: From 01/01/2022 To 12/31/2022	Worksheet S-8
	Component CCN: 15-8562		Date/Time Prepared: 5/23/2023 1:34 pm
		RHC IV	Cost

			1.00	
	Clinic Address and Identification			
1.00	Street		105 2ND STREET	1.00

		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County	ROCKPORT	IN	47635	2.00

		1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban	0	3.00

		Grant Award	Date	
		1.00	2.00	
	Source of Federal Funds			
4.00	Community Health Center (Section 330(d), PHS Act)			4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)			5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)			6.00
7.00	Appalachian Regional Commission			7.00
8.00	Look-Alikes			8.00
9.00	OTHER (SPECIFY)			9.00

		1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)	N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	CLINIC			07:30	17:00	07:30	11.00

		1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?			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	SPENCER	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	07:30	17:00	07:30	17:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA	Provider CCN: 15-1322 Component CCN: 15-8562	Period: From 01/01/2022 To 12/31/2022	Worksheet S-8 Date/Time Prepared: 5/23/2023 1:34 pm
		RHC IV	Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	07:30	17:00				11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-1322 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-10 | Date/Time Prepared: 5/23/2023 1:34 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)	0.352841	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	3,992,437	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	Y	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	16,654,630	6.00
7.00	Medicaid cost (line 1 times line 6)	5,876,436	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)	1,883,999	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	1,883,999	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)	524,268	0	524,268	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	184,983	0	184,983	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)	184,983	0	184,983	23.00

		1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	2,188,758	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	301,992	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	464,604	27.01
28.00	Non-Medicare bad debt expense (see instructions)	1,724,154	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	770,964	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	955,947	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	2,839,946	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1322 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A | Date/Time Prepared: 5/23/2023 1:34 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		2,477,424	2,477,424	111,311	2,588,735	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		1,109,914	1,109,914	0	1,109,914	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	154,902	419,867	574,769	-393	574,376	4.00
5.01	00540	ADMINISTRATIVE AND GENERAL	1,319,049	1,072,119	2,391,168	-26,332	2,364,836	5.01
5.02	00590	ADMINISTRATIVE AND GENERAL - OTHER	1,141,433	4,682,730	5,824,163	-30,769	5,793,394	5.02
7.00	00700	OPERATION OF PLANT	274,236	1,933,763	2,207,999	-3,925	2,204,074	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	72,626	72,626	0	72,626	8.00
9.00	00900	HOUSEKEEPING	316,895	207,933	524,828	0	524,828	9.00
10.00	01000	DIETARY	0	664,896	664,896	-403,281	261,615	10.00
11.00	01100	CAFETERIA	0	0	0	402,888	402,888	11.00
13.00	01300	NURSING ADMINISTRATION	419,432	60,319	479,751	0	479,751	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	194,210	150,671	344,881	-1,525	343,356	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,612,268	3,286,149	5,898,417	-219,968	5,678,449	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	718,046	1,403,969	2,122,015	-199,786	1,922,229	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	147,175	147,175	0	147,175	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	931,514	499,448	1,430,962	-1,437	1,429,525	54.00
60.00	06000	LABORATORY	763,666	1,482,662	2,246,328	-1,044	2,245,284	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	372	112,111	112,483	0	112,483	62.00
65.00	06500	RESPIRATORY THERAPY	465,635	1,056,851	1,522,486	-60,607	1,461,879	65.00
66.00	06600	PHYSICAL THERAPY	520,369	127,790	648,159	-487	647,672	66.00
67.00	06700	OCCUPATIONAL THERAPY	177,605	28,715	206,320	0	206,320	67.00
68.00	06800	SPEECH PATHOLOGY	105,522	17,697	123,219	0	123,219	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	372,507	372,507	352,009	724,516	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	113,166	113,166	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	66,448	3,605,956	3,672,404	-7,291	3,665,113	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC - TCC	1,871,432	1,223,518	3,094,950	-47,616	3,047,334	88.00
88.01	08801	RURAL HEALTH CLINIC II - PCFP	588,032	496,838	1,084,870	-388	1,084,482	88.01
88.02	08802	RURAL HEALTH CLINIC III - 13TH	1,634,745	672,887	2,307,632	-108,250	2,199,382	88.02
88.03	08803	RURAL HEALTH CLINIC IV - SPENCER	615,930	294,441	910,371	64,592	974,963	88.03
90.00	09000	CLINIC	376,032	205,840	581,872	13,723	595,595	90.00
90.01	09001	PAIN MANAGEMENT	0	0	0	0	0	90.01
90.02	09002	WOUND CARE	198,935	205,694	404,629	84,799	489,428	90.02
90.03	09003	ORTHOPEDIC CLINIC	77,406	27,416	104,822	-4,498	100,324	90.03
91.00	09100	EMERGENCY	727,603	1,677,555	2,405,158	-3,096	2,402,062	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	707,473	435,751	1,143,224	-21,795	1,121,429	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		0	0	0	0	113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	16,979,190	30,233,232	47,212,422	0	47,212,422	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	60	195,834	195,894	0	195,894	192.00
200.00		TOTAL (SUM OF LINES 118 through 199)	16,979,250	30,429,066	47,408,316	0	47,408,316	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1322 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A | Date/Time Prepared: 5/23/2023 1:34 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
		GENERAL SERVICE COST CENTERS			
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	0	2,588,735	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	260,501	1,370,415	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	574,376	4.00
5.01	00540	ADMINISTRATIVE AND GENERAL	-291,872	2,072,964	5.01
5.02	00590	ADMINISTRATIVE AND GENERAL - OTHER	-893,347	4,900,047	5.02
7.00	00700	OPERATION OF PLANT	-1,088	2,202,986	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	72,626	8.00
9.00	00900	HOUSEKEEPING	0	524,828	9.00
10.00	01000	DIETARY	-13,928	247,687	10.00
11.00	01100	CAFETERIA	-65,036	337,852	11.00
13.00	01300	NURSING ADMINISTRATION	0	479,751	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-4,896	338,460	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	-85,750	5,592,699	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	31.00
43.00	04300	NURSERY	0	0	43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	-888,006	1,034,223	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	-147,175	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,429,525	54.00
60.00	06000	LABORATORY	0	2,245,284	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	112,483	62.00
65.00	06500	RESPIRATORY THERAPY	-465,227	996,652	65.00
66.00	06600	PHYSICAL THERAPY	0	647,672	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	206,320	67.00
68.00	06800	SPEECH PATHOLOGY	0	123,219	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	724,516	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	113,166	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-2,260	3,662,853	73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC - TCC	0	3,047,334	88.00
88.01	08801	RURAL HEALTH CLINIC II - PCFP	0	1,084,482	88.01
88.02	08802	RURAL HEALTH CLINIC III - 13TH	-259	2,199,123	88.02
88.03	08803	RURAL HEALTH CLINIC IV - SPENCER	0	974,963	88.03
90.00	09000	CLINIC	-25,050	570,545	90.00
90.01	09001	PAIN MANAGEMENT	0	0	90.01
90.02	09002	WOUND CARE	-134,671	354,757	90.02
90.03	09003	ORTHOPEDIC CLINIC	0	100,324	90.03
91.00	09100	EMERGENCY	0	2,402,062	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	-1,770	1,119,659	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	102.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE	0	0	113.00
116.00	11600	HOSPICE	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-2,759,834	44,452,588	118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	195,894	192.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-2,759,834	44,648,482	200.00

RECLASSIFICATIONS | Provider CCN: 15-1322 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-6 | Date/Time Prepared: 5/23/2023 1:34 pm

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - CAFETERIA COST				
1.00	CAFETERIA	11.00	0	402,888	1.00
	0		0	402,888	
	C - LEASE EXPENSE				
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	73,773	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
	0		0	73,773	
	D - INSURANCE EXPENSE				
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	37,538	1.00
2.00		0.00	0	0	2.00
	0		0	37,538	
	E - DRUGS CHARGED				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	7,814	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
	0		0	7,814	
	F - BILLABLE SUPPLIES				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	465,175	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
	0		0	465,175	
	G - IMPLANTABLE DEVICE				
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	113,166	1.00
	0		0	113,166	
	H - WOUND CARE RECLASS				
1.00	WOUND CARE	90.02	108,622	0	1.00
2.00		0.00	0	0	2.00
	0		108,622	0	
	I - RHC RECRUITING EXPENSE RECLASS				
1.00	RURAL HEALTH CLINIC - TCC	88.00	0	4,218	1.00
2.00	RURAL HEALTH CLINIC III - 13TH	88.02	0	12,742	2.00
	0		0	16,960	
	J - IV THERAPY				
1.00	CLINIC	90.00	0	14,712	1.00
	0		0	14,712	
	L - TELL CITY RECLASS				
1.00	RURAL HEALTH CLINIC IV - SPENCER	88.03	64,592	0	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
	0		64,592	0	
500.00	Grand Total: Increases		173,214	1,132,026	500.00

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - CAFETERIA COST						
1.00	DIETARY	10.00	0	402,888	0		1.00
	0		0	402,888			
	C - LEASE EXPENSE						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	393	10		1.00
2.00	ADMINISTRATIVE AND GENERAL	5.01	0	7,199	0		2.00
3.00	ADMINISTRATIVE AND GENERAL - OTHER	5.02	0	9,121	0		3.00
4.00	OPERATION OF PLANT	7.00	0	3,925	0		4.00
5.00	DIETARY	10.00	0	393	0		5.00
6.00	MEDICAL RECORDS & LIBRARY	16.00	0	1,525	0		6.00
7.00	ADULTS & PEDIATRICS	30.00	0	3,991	0		7.00
8.00	OPERATING ROOM	50.00	0	10,093	0		8.00
9.00	RADIOLOGY-DIAGNOSTIC	54.00	0	1,437	0		9.00
10.00	LABORATORY	60.00	0	1,044	0		10.00
11.00	RESPIRATORY THERAPY	65.00	0	24,933	0		11.00
12.00	PHYSICAL THERAPY	66.00	0	393	0		12.00
13.00	DRUGS CHARGED TO PATIENTS	73.00	0	393	0		13.00
14.00	CLINIC	90.00	0	956	0		14.00
15.00	WOUND CARE	90.02	0	393	0		15.00
16.00	EMERGENCY	91.00	0	1,679	0		16.00
17.00	AMBULANCE SERVICES	95.00	0	5,905	0		17.00
	0		0	73,773			
	D - INSURANCE EXPENSE						
1.00	ADMINISTRATIVE AND GENERAL - OTHER	5.02	0	21,648	12		1.00
2.00	AMBULANCE SERVICES	95.00	0	15,890	0		2.00
	0		0	37,538			
	E - DRUGS CHARGED						
1.00	ADMINISTRATIVE AND GENERAL	5.01	0	2,173	0		1.00
2.00	WOUND CARE	90.02	0	1,143	0		2.00
3.00	ORTHOPEDIC CLINIC	90.03	0	4,498	0		3.00
	0		0	7,814			
	F - BILLABLE SUPPLIES						
1.00	ADULTS & PEDIATRICS	30.00	0	215,977	0		1.00
2.00	OPERATING ROOM	50.00	0	189,693	0		2.00
3.00	RESPIRATORY THERAPY	65.00	0	35,674	0		3.00
4.00	PHYSICAL THERAPY	66.00	0	94	0		4.00
5.00	CLINIC	90.00	0	33	0		5.00
6.00	WOUND CARE	90.02	0	22,287	0		6.00
7.00	EMERGENCY	91.00	0	1,417	0		7.00
	0		0	465,175			
	G - IMPLANTABLE DEVICE						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	113,166	0		1.00
	0		0	113,166			
	H - WOUND CARE RECLASS						
1.00	RURAL HEALTH CLINIC - TCC	88.00	25,979	0	0		1.00
2.00	RURAL HEALTH CLINIC III - 13TH	88.02	82,643	0	0		2.00
	0		108,622	0			
	I - RHC RECRUITING EXPENSE RECLASS						
1.00	ADMINISTRATIVE AND GENERAL	5.01	0	16,960	0		1.00
2.00		0.00	0	0	0		2.00
	0		0	16,960			
	J - IV THERAPY						
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	14,712	0		1.00
	0		0	14,712			
	L - TELL CITY RECLASS						
1.00	RURAL HEALTH CLINIC - TCC	88.00	25,855	0	0		1.00
2.00	RURAL HEALTH CLINIC II - PCFP	88.01	388	0	0		2.00
3.00	RURAL HEALTH CLINIC III - 13TH	88.02	38,349	0	0		3.00
	0		64,592	0			
500.00	Grand Total: Decreases		173,214	1,132,026			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1322 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-7 Part I Date/Time Prepared: 5/23/2023 1:34 pm

		Beginning Balances	Acquisitions Purchases	Donation	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	3,805,753	0	0	0	112,375	1.00
2.00	Land Improvements	272,277	0	0	0	226,619	2.00
3.00	Buildings and Fixtures	43,981,242	54,991	0	54,991	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	2,606,705	0	0	0	0	5.00
6.00	Movable Equipment	18,486,521	1,296,403	0	1,296,403	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	69,152,498	1,351,394	0	1,351,394	338,994	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	69,152,498	1,351,394	0	1,351,394	338,994	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	3,693,378	0	1.00
2.00	Land Improvements	45,658	0	2.00
3.00	Buildings and Fixtures	44,036,233	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	2,606,705	0	5.00
6.00	Movable Equipment	19,782,924	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	70,164,898	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	70,164,898	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1322 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-7 Part II | Date/Time Prepared: 5/23/2023 1:34 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	2,470,773	0	0	0	6,651	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	1,109,914	0	0	2.00
3.00	Total (sum of lines 1-2)	2,470,773	0	1,109,914	0	6,651	3.00

	Cost Center Description	SUMMARY OF CAPITAL		
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	2,477,424	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	1,109,914	2.00
3.00	Total (sum of lines 1-2)	0	3,587,338	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1322 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-7 Part III Date/Time Prepared: 5/23/2023 1:34 pm

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	50,381,974	0	50,381,974	0.718051	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	19,782,924	0	19,782,924	0.281949	0	2.00
3.00	Total (sum of lines 1-2)	70,164,898	0	70,164,898	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	2,470,773	73,773	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	260,501	2.00
3.00	Total (sum of lines 1-2)	0	0	0	2,470,773	334,274	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	37,538	6,651	0	2,588,735	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	1,109,914	0	0	0	1,370,415	2.00
3.00	Total (sum of lines 1-2)	1,109,914	37,538	6,651	0	3,959,150	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1322 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-8 | Date/Time Prepared: 5/23/2023 1:34 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
				Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)	A	195,152	NEW CAP REL COSTS-MVBLE EQUIP	2.00	10	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)	A	-5,261	ADMINISTRATIVE AND GENERAL - OTHER	5.02	0	7.00
8.00	Television and radio service (chapter 21)	A	-1,088	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	-1,744,307			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	65,349			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-65,036	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	-2,260	DRUGS CHARGED TO PATIENTS	73.00	0	17.00
18.00	Sale of medical records and abstracts	B	-4,896	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines	B	-13,928	DIETARY	10.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP		0	NEW 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: 15-1322 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-8 | Date/Time Prepared: 5/23/2023 1:34 pm

				Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
	Cost Center Description	Basis/Code (2)	Amount	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		0		0.00	0	32.00
33.00	ADMINISTRATION MISCELLANEOUS REVENUE	B	-211,136	ADMINISTRATIVE AND GENERAL	5.01	0	33.00
33.01	NONPATIENT SERVICES-CPR/EDU CLASSES-	B	-1,770	AMBULANCE SERVICES	95.00	0	33.01
33.02	ADMINISTRATION-MISC EXPENSES	A	-47,089	ADMINISTRATIVE AND GENERAL - OTHER	5.02	0	33.02
33.03	MISCELLANEOUS RENTAL INCOME - A&G	B	-52,718	ADMINISTRATIVE AND GENERAL	5.01	0	33.03
33.04	OTHER CLINIC REVENUE	B	-1,050	CLINIC	90.00	0	33.04
33.05	WOUND CENTER-ADVERTISING	A	-522	WOUND CARE	90.02	0	33.05
33.06	ADMINISTRATION-MISC EXPENSES	A	-22,591	ADMINISTRATIVE AND GENERAL	5.01	0	33.06
33.07	HAF FEES	B	-840,997	ADMINISTRATIVE AND GENERAL - OTHER	5.02	0	33.07
33.08	LOBBYING DUES	A	-5,427	ADMINISTRATIVE AND GENERAL	5.01	0	33.08
33.09	RHC III-MISC EXPENSES	A	-259	RURAL HEALTH CLINIC III - 13TH	88.02	0	33.09
33.10	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.10
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-2,759,834				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: 15-1322	Period: From 01/01/2022 To 12/31/2022	Worksheet A-8-1 Date/Time Prepared: 5/23/2023 1:34 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	2.00	NEW CAP REL COSTS-MVBLE EQUI	AMBULANCE DEPRECIATION	65,349	0	1.00
2.00	0.00			0	0	2.00
3.00	0.00			0	0	3.00
4.00	0.00			0	0	4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			65,349	0	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.

	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	
6.00	B	PERRY CO AMBULA	100.00		0.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:	OTHER				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: 15-1322	Period: From 01/01/2022 To 12/31/2022	Worksheet A-8-1 Date/Time Prepared: 5/23/2023 1:34 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	65,349	10	1.00
2.00	0	0	2.00
3.00	0	0	3.00
4.00	0	0	4.00
5.00	65,349		5.00

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

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

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

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

6.00			6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-1322 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-8-2 | Date/Time Prepared: 5/23/2023 1:34 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	928,283	85,750	842,533	0	0	1.00
2.00	50.00	OPERATING ROOM	888,006	888,006	0	0	0	2.00
3.00	52.00	DELIVERY ROOM & LABOR ROOM	147,175	147,175	0	0	0	3.00
4.00	60.00	LABORATORY	18,000	0	18,000	0	0	4.00
5.00	65.00	RESPIRATORY THERAPY	465,227	465,227	0	0	0	5.00
6.00	90.00	CLINIC	24,000	24,000	0	0	0	6.00
7.00	90.02	WOUND CARE	134,149	134,149	0	0	0	7.00
8.00	91.00	EMERGENCY	1,377,126	0	1,377,126	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			3,981,966	1,744,307	2,237,659		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	50.00	OPERATING ROOM	0	0	0	0	0	2.00
3.00	52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	3.00
4.00	60.00	LABORATORY	0	0	0	0	0	4.00
5.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	5.00
6.00	90.00	CLINIC	0	0	0	0	0	6.00
7.00	90.02	WOUND CARE	0	0	0	0	0	7.00
8.00	91.00	EMERGENCY	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	85,750	1.00
2.00	50.00	OPERATING ROOM	0	0	0	888,006	2.00
3.00	52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	147,175	3.00
4.00	60.00	LABORATORY	0	0	0	0	4.00
5.00	65.00	RESPIRATORY THERAPY	0	0	0	465,227	5.00
6.00	90.00	CLINIC	0	0	0	24,000	6.00
7.00	90.02	WOUND CARE	0	0	0	134,149	7.00
8.00	91.00	EMERGENCY	0	0	0	0	8.00
9.00	0.00		0	0	0	0	9.00
10.00	0.00		0	0	0	0	10.00
200.00			0	0	0	1,744,307	200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1322 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part I Date/Time Prepared: 5/23/2023 1:34 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				NEW BLDG & FIXT	NEW MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	2,588,735	2,588,735				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	1,370,415		1,370,415			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	574,376	12,324	6,524	593,224		4.00
5.01	00540	ADMINISTRATIVE AND GENERAL	2,072,964	199,353	105,533	46,510	2,424,360	5.01
5.02	00590	ADMINISTRATIVE AND GENERAL - OTHER	4,900,047	164,728	87,203	40,247	5,192,225	5.02
7.00	00700	OPERATION OF PLANT	2,202,986	499,748	264,555	9,670	2,976,959	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	72,626	4,264	2,257	0	79,147	8.00
9.00	00900	HOUSEKEEPING	524,828	28,677	15,181	11,174	579,860	9.00
10.00	01000	DIETARY	247,687	108,781	57,586	0	414,054	10.00
11.00	01100	CAFETERIA	337,852	0	0	0	337,852	11.00
13.00	01300	NURSING ADMINISTRATION	479,751	5,757	3,047	14,789	503,344	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	338,460	31,982	16,930	6,848	394,220	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,592,699	378,920	200,591	92,108	6,264,318	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	0	15,479	8,194	0	23,673	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,034,223	278,519	147,441	25,318	1,485,501	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	68,334	36,175	0	104,509	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,429,525	140,976	74,629	32,845	1,677,975	54.00
60.00	06000	LABORATORY	2,245,284	58,250	30,836	26,927	2,361,297	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	112,483	0	0	13	112,496	62.00
65.00	06500	RESPIRATORY THERAPY	996,652	87,587	46,367	16,418	1,147,024	65.00
66.00	06600	PHYSICAL THERAPY	647,672	43,069	22,800	18,348	731,889	66.00
67.00	06700	OCCUPATIONAL THERAPY	206,320	18,699	9,899	6,262	241,180	67.00
68.00	06800	SPEECH PATHOLOGY	123,219	9,829	5,203	3,721	141,972	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	724,516	0	0	0	724,516	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	113,166	0	0	0	113,166	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,662,853	32,131	17,009	2,343	3,714,336	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC - TCC	3,047,334	0	0	64,159	3,111,493	88.00
88.01	08801	RURAL HEALTH CLINIC II - PCFP	1,084,482	0	0	20,720	1,105,202	88.01
88.02	08802	RURAL HEALTH CLINIC III - 13TH	2,199,123	0	0	53,375	2,252,498	88.02
88.03	08803	RURAL HEALTH CLINIC IV - SPENCER	974,963	0	0	23,995	998,958	88.03
90.00	09000	CLINIC	570,545	95,839	50,735	13,259	730,378	90.00
90.01	09001	PAIN MANAGEMENT	0	0	0	0	0	90.01
90.02	09002	WOUND CARE	354,757	33,730	17,856	10,844	417,187	90.02
90.03	09003	ORTHOPEDIC CLINIC	100,324	0	0	2,729	103,053	90.03
91.00	09100	EMERGENCY	2,402,062	146,199	77,395	25,655	2,651,311	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,119,659	95,945	50,791	24,945	1,291,340	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	44,452,588	2,559,120	1,354,737	593,222	44,407,293	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	29,615	15,678	0	45,293	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	195,894	0	0	2	195,896	192.00
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)	44,648,482	2,588,735	1,370,415	593,224	44,648,482	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1322 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part I | Date/Time Prepared: 5/23/2023 1:34 pm

		Cost Center Description	ADMINISTRATIVE AND GENERAL	Subtotal	ADMINISTRATIVE AND GENERAL - OTHER	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			5.01	5A.01	5.02	7.00	8.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	ADMINISTRATIVE AND GENERAL	2,424,360					5.01
5.02	00590	ADMINISTRATIVE AND GENERAL - OTHER	298,117	5,490,342	5,490,342			5.02
7.00	00700	OPERATION OF PLANT	170,925	3,147,884	443,710	3,591,594		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	4,544	83,691	11,797	8,943	104,431	8.00
9.00	00900	HOUSEKEEPING	33,293	613,153	86,427	60,141	14,207	9.00
10.00	01000	DIETARY	23,773	437,827	61,714	228,133	0	10.00
11.00	01100	CAFETERIA	19,398	357,250	50,356	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	28,900	532,244	75,022	12,073	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	22,635	416,855	58,758	67,072	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	359,692	6,624,010	933,691	794,661	33,652	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	1,359	25,032	3,528	32,463	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	85,292	1,570,793	221,411	584,104	6,047	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	6,000	110,509	15,577	143,310	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	96,343	1,774,318	250,099	295,652	12,593	54.00
60.00	06000	LABORATORY	135,576	2,496,873	351,947	122,160	436	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	6,459	118,955	16,767	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	65,858	1,212,882	170,962	183,687	2,716	65.00
66.00	06600	PHYSICAL THERAPY	42,022	773,911	109,087	90,323	1,870	66.00
67.00	06700	OCCUPATIONAL THERAPY	13,848	255,028	35,947	39,215	0	67.00
68.00	06800	SPEECH PATHOLOGY	8,151	150,123	21,161	20,613	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	41,599	766,115	107,988	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	6,498	119,664	16,867	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	213,262	3,927,598	553,615	67,385	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC - TCC	178,649	3,290,142	463,762	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II - PCFP	63,456	1,168,658	164,728	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III - 13TH	129,329	2,381,827	335,730	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV - SPENCER	57,356	1,056,314	148,893	0	0	88.03
90.00	09000	CLINIC	41,935	772,313	108,861	200,991	3,254	90.00
90.01	09001	PAIN MANAGEMENT	0	0	0	0	0	90.01
90.02	09002	WOUND CARE	23,953	441,140	62,181	70,738	0	90.02
90.03	09003	ORTHOPEDIC CLINIC	5,917	108,970	15,360	0	0	90.03
91.00	09100	EMERGENCY	152,228	2,803,539	395,173	306,607	29,477	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0				92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	74,144	1,365,484	192,472	201,215	179	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,410,511	44,393,444	5,483,591	3,529,486	104,431	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,601	47,894	6,751	62,108	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	11,248	207,144	0	0	0	192.00
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)	2,424,360	44,648,482	5,490,342	3,591,594	104,431	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1322 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part I Date/Time Prepared: 5/23/2023 1:34 pm

		Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	
			9.00	10.00	11.00	13.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	ADMINISTRATIVE AND GENERAL						5.01
5.02	00590	ADMINISTRATIVE AND GENERAL - OTHER						5.02
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	773,928					9.00
10.00	01000	DIETARY	50,123	777,797				10.00
11.00	01100	CAFETERIA	0	0	407,606			11.00
13.00	01300	NURSING ADMINISTRATION	2,653	0	13,069	635,061		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	14,736	0	14,881	0	572,302	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	174,594	777,797	119,402	373,415	165,860	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	7,132	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	128,333	0	28,565	89,388	7,290	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	31,486	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	64,957	0	46,486	0	21,871	54.00
60.00	06000	LABORATORY	26,840	0	48,945	0	27,339	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	40,358	0	25,330	0	25,517	65.00
66.00	06600	PHYSICAL THERAPY	19,845	0	22,839	0	7,290	66.00
67.00	06700	OCCUPATIONAL THERAPY	8,616	0	7,796	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	4,529	0	3,947	0	7,290	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	14,805	0	4,626	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC - TCC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II - PCFP	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III - 13TH	0	0	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV - SPENCER	0	0	0	0	0	88.03
90.00	09000	CLINIC	44,160	0	17,631	55,162	145,809	90.00
90.01	09001	PAIN MANAGEMENT	0	0	0	0	0	90.01
90.02	09002	WOUND CARE	15,542	0	11,258	0	0	90.02
90.03	09003	ORTHOPEDIC CLINIC	0	0	5,402	0	0	90.03
91.00	09100	EMERGENCY	67,364	0	37,429	117,096	164,036	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	44,209	0	0	0	0	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	760,282	777,797	407,606	635,061	572,302	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	13,646	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
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)	773,928	777,797	407,606	635,061	572,302	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1322 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part I Date/Time Prepared: 5/23/2023 1:34 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.01	00540	ADMINISTRATIVE AND GENERAL				5.01
5.02	00590	ADMINISTRATIVE AND GENERAL - OTHER				5.02
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
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	9,997,082	0	9,997,082	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	31.00
43.00	04300	NURSERY	68,155	0	68,155	43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	2,635,931	0	2,635,931	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	300,882	0	300,882	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,465,976	0	2,465,976	54.00
60.00	06000	LABORATORY	3,074,540	0	3,074,540	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	135,722	0	135,722	62.00
65.00	06500	RESPIRATORY THERAPY	1,661,452	0	1,661,452	65.00
66.00	06600	PHYSICAL THERAPY	1,025,165	0	1,025,165	66.00
67.00	06700	OCCUPATIONAL THERAPY	346,602	0	346,602	67.00
68.00	06800	SPEECH PATHOLOGY	207,663	0	207,663	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	874,103	0	874,103	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	136,531	0	136,531	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,568,029	0	4,568,029	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC - TCC	3,753,904	0	3,753,904	88.00
88.01	08801	RURAL HEALTH CLINIC II - PCFP	1,333,386	0	1,333,386	88.01
88.02	08802	RURAL HEALTH CLINIC III - 13TH	2,717,557	0	2,717,557	88.02
88.03	08803	RURAL HEALTH CLINIC IV - SPENCER	1,205,207	0	1,205,207	88.03
90.00	09000	CLINIC	1,348,181	0	1,348,181	90.00
90.01	09001	PAIN MANAGEMENT	0	0	0	90.01
90.02	09002	WOUND CARE	600,859	0	600,859	90.02
90.03	09003	ORTHOPEDIC CLINIC	129,732	0	129,732	90.03
91.00	09100	EMERGENCY	3,920,721	0	3,920,721	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	1,803,559	0	1,803,559	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
116.00	11600	HOSPICE	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	44,310,939	0	44,310,939	118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	130,399	0	130,399	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	207,144	0	207,144	192.00
200.00		Cross Foot Adjustments	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	44,648,482	0	44,648,482	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1322 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part II Date/Time Prepared: 5/23/2023 1:34 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	NEW MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	12,324	6,524	18,848	18,848	4.00
5.01	00540	ADMINISTRATIVE AND GENERAL	0	199,353	105,533	304,886	1,477	5.01
5.02	00590	ADMINISTRATIVE AND GENERAL - OTHER	0	164,728	87,203	251,931	1,278	5.02
7.00	00700	OPERATION OF PLANT	0	499,748	264,555	764,303	307	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	4,264	2,257	6,521	0	8.00
9.00	00900	HOUSEKEEPING	0	28,677	15,181	43,858	355	9.00
10.00	01000	DIETARY	0	108,781	57,586	166,367	0	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	5,757	3,047	8,804	470	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	31,982	16,930	48,912	218	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	378,920	200,591	579,511	2,933	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	0	15,479	8,194	23,673	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	278,519	147,441	425,960	804	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	68,334	36,175	104,509	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	140,976	74,629	215,605	1,043	54.00
60.00	06000	LABORATORY	0	58,250	30,836	89,086	855	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	87,587	46,367	133,954	522	65.00
66.00	06600	PHYSICAL THERAPY	0	43,069	22,800	65,869	583	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	18,699	9,899	28,598	199	67.00
68.00	06800	SPEECH PATHOLOGY	0	9,829	5,203	15,032	118	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	32,131	17,009	49,140	74	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC - TCC	0	0	0	0	2,038	88.00
88.01	08801	RURAL HEALTH CLINIC II - PCFP	0	0	0	0	658	88.01
88.02	08802	RURAL HEALTH CLINIC III - 13TH	0	0	0	0	1,695	88.02
88.03	08803	RURAL HEALTH CLINIC IV - SPENCER	0	0	0	0	762	88.03
90.00	09000	CLINIC	0	95,839	50,735	146,574	421	90.00
90.01	09001	PAIN MANAGEMENT	0	0	0	0	0	90.01
90.02	09002	WOUND CARE	0	33,730	17,856	51,586	344	90.02
90.03	09003	ORTHOPEDIC CLINIC	0	0	0	0	87	90.03
91.00	09100	EMERGENCY	0	146,199	77,395	223,594	815	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	95,945	50,791	146,736	792	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	2,559,120	1,354,737	3,913,857	18,848	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	29,615	15,678	45,293	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	2,588,735	1,370,415	3,959,150	18,848	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1322 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part II Date/Time Prepared: 5/23/2023 1:34 pm

		Cost Center Description	ADMINISTRATIVE AND GENERAL	ADMINISTRATIVE AND GENERAL - OTHER	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.01	5.02	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	ADMINISTRATIVE AND GENERAL	306,363					5.01
5.02	00590	ADMINISTRATIVE AND GENERAL - OTHER	37,675	290,884				5.02
7.00	00700	OPERATION OF PLANT	21,601	23,508	809,719			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	574	625	2,016	9,736		8.00
9.00	00900	HOUSEKEEPING	4,207	4,579	13,559	1,324	67,882	9.00
10.00	01000	DIETARY	3,004	3,270	51,432	0	4,396	10.00
11.00	01100	CAFETERIA	2,451	2,668	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	3,652	3,975	2,722	0	233	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,860	3,113	15,121	0	1,293	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	45,441	49,464	179,155	3,138	15,312	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	172	187	7,319	0	626	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,779	11,731	131,685	564	11,256	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	758	825	32,309	0	2,762	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,175	13,251	66,654	1,174	5,697	54.00
60.00	06000	LABORATORY	17,134	18,647	27,541	41	2,354	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	816	888	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	8,323	9,058	41,412	253	3,540	65.00
66.00	06600	PHYSICAL THERAPY	5,311	5,780	20,363	174	1,741	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,750	1,905	8,841	0	756	67.00
68.00	06800	SPEECH PATHOLOGY	1,030	1,121	4,647	0	397	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,257	5,721	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	821	894	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	26,951	29,331	15,192	0	1,299	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC - TCC	22,577	24,571	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II - PCFP	8,019	8,728	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III - 13TH	16,344	17,787	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV - SPENCER	7,248	7,889	0	0	0	88.03
90.00	09000	CLINIC	5,300	5,768	45,313	303	3,873	90.00
90.01	09001	PAIN MANAGEMENT	0	0	0	0	0	90.01
90.02	09002	WOUND CARE	3,027	3,294	15,948	0	1,363	90.02
90.03	09003	ORTHOPEDIC CLINIC	748	814	0	0	0	90.03
91.00	09100	EMERGENCY	19,238	20,937	69,124	2,748	5,909	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	9,370	10,197	45,364	17	3,878	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	304,613	290,526	795,717	9,736	66,685	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	329	358	14,002	0	1,197	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,421	0	0	0	0	192.00
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)	306,363	290,884	809,719	9,736	67,882	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1322 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part II Date/Time Prepared: 5/23/2023 1:34 pm

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	Subtotal	
			10.00	11.00	13.00	16.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	ADMINISTRATIVE AND GENERAL						5.01
5.02	00590	ADMINISTRATIVE AND GENERAL - OTHER						5.02
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	228,469					10.00
11.00	01100	CAFETERIA	0	5,119				11.00
13.00	01300	NURSING ADMINISTRATION	0	164	20,020			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	187	0	71,704		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	228,469	1,499	11,772	20,782	1,137,476	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	0	0	0	0	31,977	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	359	2,818	913	596,869	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	141,163	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	584	0	2,740	318,923	54.00
60.00	06000	LABORATORY	0	615	0	3,425	159,698	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	1,704	62.00
65.00	06500	RESPIRATORY THERAPY	0	318	0	3,197	200,577	65.00
66.00	06600	PHYSICAL THERAPY	0	287	0	913	101,021	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	98	0	0	42,147	67.00
68.00	06800	SPEECH PATHOLOGY	0	50	0	913	23,308	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	10,978	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	1,715	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	58	0	0	122,045	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC - TCC	0	0	0	0	49,186	88.00
88.01	08801	RURAL HEALTH CLINIC II - PCFP	0	0	0	0	17,405	88.01
88.02	08802	RURAL HEALTH CLINIC III - 13TH	0	0	0	0	35,826	88.02
88.03	08803	RURAL HEALTH CLINIC IV - SPENCER	0	0	0	0	15,899	88.03
90.00	09000	CLINIC	0	221	1,739	18,269	227,781	90.00
90.01	09001	PAIN MANAGEMENT	0	0	0	0	0	90.01
90.02	09002	WOUND CARE	0	141	0	0	75,703	90.02
90.03	09003	ORTHOPEDIC CLINIC	0	68	0	0	1,717	90.03
91.00	09100	EMERGENCY	0	470	3,691	20,552	367,078	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	216,354	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	228,469	5,119	20,020	71,704	3,896,550	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	61,179	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	1,421	192.00
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)	228,469	5,119	20,020	71,704	3,959,150	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1322 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part II Date/Time Prepared: 5/23/2023 1:34 pm

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			25.00	26.00	
		GENERAL SERVICE COST CENTERS			
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.01	00540	ADMINISTRATIVE AND GENERAL			5.01
5.02	00590	ADMINISTRATIVE AND GENERAL - OTHER			5.02
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
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	0	1,137,476	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	31.00
43.00	04300	NURSERY	0	31,977	43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	596,869	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	141,163	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	318,923	54.00
60.00	06000	LABORATORY	0	159,698	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	1,704	62.00
65.00	06500	RESPIRATORY THERAPY	0	200,577	65.00
66.00	06600	PHYSICAL THERAPY	0	101,021	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	42,147	67.00
68.00	06800	SPEECH PATHOLOGY	0	23,308	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	10,978	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	1,715	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	122,045	73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC - TCC	0	49,186	88.00
88.01	08801	RURAL HEALTH CLINIC II - PCFP	0	17,405	88.01
88.02	08802	RURAL HEALTH CLINIC III - 13TH	0	35,826	88.02
88.03	08803	RURAL HEALTH CLINIC IV - SPENCER	0	15,899	88.03
90.00	09000	CLINIC	0	227,781	90.00
90.01	09001	PAIN MANAGEMENT	0	0	90.01
90.02	09002	WOUND CARE	0	75,703	90.02
90.03	09003	ORTHOPEDIC CLINIC	0	1,717	90.03
91.00	09100	EMERGENCY	0	367,078	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0	216,354	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	102.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
116.00	11600	HOSPICE	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	3,896,550	118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	61,179	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,421	192.00
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	3,959,150	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1322 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B-1 | Date/Time Prepared: 5/23/2023 1:34 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE AND GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A.01	5.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	121,416					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		121,416				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	578	578	16,824,348			4.00
5.01	00540	ADMINISTRATIVE AND GENERAL	9,350	9,350	1,319,049	-2,424,360	42,224,122	5.01
5.02	00590	ADMINISTRATIVE AND GENERAL - OTHER	7,726	7,726	1,141,433	0	5,192,225	5.02
7.00	00700	OPERATION OF PLANT	23,439	23,439	274,236	0	2,976,959	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	200	200	0	0	79,147	8.00
9.00	00900	HOUSEKEEPING	1,345	1,345	316,895	0	579,860	9.00
10.00	01000	DIETARY	5,102	5,102	0	0	414,054	10.00
11.00	01100	CAFETERIA	0	0	0	0	337,852	11.00
13.00	01300	NURSING ADMINISTRATION	270	270	419,432	0	503,344	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,500	1,500	194,210	0	394,220	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	17,772	17,772	2,612,268	0	6,264,318	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	726	726	0	0	23,673	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	13,063	13,063	718,046	0	1,485,501	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,205	3,205	0	0	104,509	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,612	6,612	931,514	0	1,677,975	54.00
60.00	06000	LABORATORY	2,732	2,732	763,666	0	2,361,297	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	372	0	112,496	62.00
65.00	06500	RESPIRATORY THERAPY	4,108	4,108	465,635	0	1,147,024	65.00
66.00	06600	PHYSICAL THERAPY	2,020	2,020	520,369	0	731,889	66.00
67.00	06700	OCCUPATIONAL THERAPY	877	877	177,605	0	241,180	67.00
68.00	06800	SPEECH PATHOLOGY	461	461	105,522	0	141,972	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	724,516	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	113,166	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,507	1,507	66,448	0	3,714,336	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC - TCC	0	0	1,819,598	0	3,111,493	88.00
88.01	08801	RURAL HEALTH CLINIC II - PCFP	0	0	587,644	0	1,105,202	88.01
88.02	08802	RURAL HEALTH CLINIC III - 13TH	0	0	1,513,753	0	2,252,498	88.02
88.03	08803	RURAL HEALTH CLINIC IV - SPENCER	0	0	680,522	0	998,958	88.03
90.00	09000	CLINIC	4,495	4,495	376,032	0	730,378	90.00
90.01	09001	PAIN MANAGEMENT	0	0	0	0	0	90.01
90.02	09002	WOUND CARE	1,582	1,582	307,557	0	417,187	90.02
90.03	09003	ORTHOPEDIC CLINIC	0	0	77,406	0	103,053	90.03
91.00	09100	EMERGENCY	6,857	6,857	727,603	0	2,651,311	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	4,500	4,500	707,473	0	1,291,340	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	120,027	120,027	16,824,288	-2,424,360	41,982,933	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,389	1,389	0	0	45,293	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	60	0	195,896	192.00
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)	2,588,735	1,370,415	593,224		2,424,360	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	21.321201	11.286939	0.035260		0.057416	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			18,848		306,363	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.001120		0.007256	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: 15-1322 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B-1 | Date/Time Prepared: 5/23/2023 1:34 pm

		Cost Center Description	Reconciliation	ADMINISTRATIVE AND GENERAL - OTHER (ACCUM. COST NO PBP)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	
			5A.02	5.02	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	ADMINISTRATIVE AND GENERAL						5.01
5.02	00590	ADMINISTRATIVE AND GENERAL - OTHER	-5,490,342	38,950,996				5.02
7.00	00700	OPERATION OF PLANT	0	3,147,884	80,323			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	83,691	200	8,152		8.00
9.00	00900	HOUSEKEEPING	0	613,153	1,345	1,109	78,778	9.00
10.00	01000	DIETARY	0	437,827	5,102	0	5,102	10.00
11.00	01100	CAFETERIA	0	357,250	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	532,244	270	0	270	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	416,855	1,500	0	1,500	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	6,624,010	17,772	2,627	17,772	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	0	25,032	726	0	726	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,570,793	13,063	472	13,063	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	110,509	3,205	0	3,205	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,774,318	6,612	983	6,612	54.00
60.00	06000	LABORATORY	0	2,496,873	2,732	34	2,732	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	118,955	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	1,212,882	4,108	212	4,108	65.00
66.00	06600	PHYSICAL THERAPY	0	773,911	2,020	146	2,020	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	255,028	877	0	877	67.00
68.00	06800	SPEECH PATHOLOGY	0	150,123	461	0	461	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	766,115	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	119,664	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,927,598	1,507	0	1,507	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC - TCC	0	3,290,142	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II - PCFP	0	1,168,658	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III - 13TH	0	2,381,827	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV - SPENCER	0	1,056,314	0	0	0	88.03
90.00	09000	CLINIC	0	772,313	4,495	254	4,495	90.00
90.01	09001	PAIN MANAGEMENT	0	0	0	0	0	90.01
90.02	09002	WOUND CARE	0	441,140	1,582	0	1,582	90.02
90.03	09003	ORTHOPEDIC CLINIC	0	108,970	0	0	0	90.03
91.00	09100	EMERGENCY	0	2,803,539	6,857	2,301	6,857	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	1,365,484	4,500	14	4,500	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-5,490,342	38,903,102	78,934	8,152	77,389	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	47,894	1,389	0	1,389	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	-207,144	0	0	0	0	192.00
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)		5,490,342	3,591,594	104,431	773,928	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)		0.140955	44.714391	12.810476	9.824164	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		290,884	809,719	9,736	67,882	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.007468	10.080786	1.194308	0.861687	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: 15-1322 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B-1 | Date/Time Prepared: 5/23/2023 1:34 pm

		Cost Center Description	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	MEDICAL RECORDS & LIBRARY (TIME SPENT)		
			10.00	11.00	13.00	16.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	ADMINISTRATIVE AND GENERAL						5.01
5.02	00590	ADMINISTRATIVE AND GENERAL - OTHER						5.02
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	9,932					10.00
11.00	01100	CAFETERIA	0	12,600				11.00
13.00	01300	NURSING ADMINISTRATION	0	404	130,553			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	460	0	314		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,932	3,691	76,765	91		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0		31.00
43.00	04300	NURSERY	0	0	0	0		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	883	18,376	4		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,437	0	12		54.00
60.00	06000	LABORATORY	0	1,513	0	15		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0		62.00
65.00	06500	RESPIRATORY THERAPY	0	783	0	14		65.00
66.00	06600	PHYSICAL THERAPY	0	706	0	4		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	241	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	122	0	4		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	143	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC - TCC	0	0	0	0		88.00
88.01	08801	RURAL HEALTH CLINIC II - PCFP	0	0	0	0		88.01
88.02	08802	RURAL HEALTH CLINIC III - 13TH	0	0	0	0		88.02
88.03	08803	RURAL HEALTH CLINIC IV - SPENCER	0	0	0	0		88.03
90.00	09000	CLINIC	0	545	11,340	80		90.00
90.01	09001	PAIN MANAGEMENT	0	0	0	0		90.01
90.02	09002	WOUND CARE	0	348	0	0		90.02
90.03	09003	ORTHOPEDIC CLINIC	0	167	0	0		90.03
91.00	09100	EMERGENCY	0	1,157	24,072	90		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0		95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0		102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	9,932	12,600	130,553	314		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
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)	777,797	407,606	635,061	572,302		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	78.312223	32.349683	4.864392	1,822.617834		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	228,469	5,119	20,020	71,704		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	23.003323	0.406270	0.153348	228.356688		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: 15-1322 | Period: From 01/01/2022 To 12/31/2022 | Worksheet C Part I | Date/Time Prepared: 5/23/2023 1:34 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
					Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,997,082		9,997,082	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0		0	0	0	31.00
43.00	04300	NURSERY	68,155		68,155	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,635,931		2,635,931	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	300,882		300,882	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,465,976		2,465,976	0	0	54.00
60.00	06000	LABORATORY	3,074,540		3,074,540	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	135,722		135,722	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	1,661,452	0	1,661,452	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,025,165	0	1,025,165	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	346,602	0	346,602	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	207,663	0	207,663	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	874,103		874,103	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	136,531		136,531	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,568,029		4,568,029	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC - TCC	3,753,904		3,753,904	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II - PCFP	1,333,386		1,333,386	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III - 13TH	2,717,557		2,717,557	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV - SPENCER	1,205,207		1,205,207	0	0	88.03
90.00	09000	CLINIC	1,348,181		1,348,181	0	0	90.00
90.01	09001	PAIN MANAGEMENT	0		0	0	0	90.01
90.02	09002	WOUND CARE	600,859		600,859	0	0	90.02
90.03	09003	ORTHOPEDIC CLINIC	129,732		129,732	0	0	90.03
91.00	09100	EMERGENCY	3,920,721		3,920,721	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,502,470		1,502,470		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,803,559		1,803,559	0	0	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0		0		0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0		0		0	116.00
200.00		Subtotal (see instructions)	45,813,409	0	45,813,409	0	0	200.00
201.00		Less Observation Beds	1,502,470		1,502,470		0	201.00
202.00		Total (see instructions)	44,310,939	0	44,310,939	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-1322 | Period: From 01/01/2022 To 12/31/2022 | Worksheet C Part I | Date/Time Prepared: 5/23/2023 1:34 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	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	5,374,008		5,374,008			30.00
31.00	03100	INTENSIVE CARE UNIT	0		0			31.00
43.00	04300	NURSERY	120,720		120,720			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	975,904	8,237,177	9,213,081	0.286107	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	529,008	122,023	651,031	0.462162	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	907,377	17,084,485	17,991,862	0.137061	0.000000	54.00
60.00	06000	LABORATORY	1,613,747	18,905,252	20,518,999	0.149839	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	54,878	378,844	433,722	0.312924	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	1,150,591	3,842,252	4,992,843	0.332767	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	654,276	2,361,787	3,016,063	0.339902	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	556,907	764,240	1,321,147	0.262349	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	163,228	507,730	670,958	0.309502	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,542,013	3,092,577	4,634,590	0.188604	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,312	206,913	208,225	0.655690	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,684,135	17,571,937	20,256,072	0.225514	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC - TCC	0	5,567,354	5,567,354			88.00
88.01	08801	RURAL HEALTH CLINIC II - PCFP	0	2,151,240	2,151,240			88.01
88.02	08802	RURAL HEALTH CLINIC III - 13TH	0	2,872,301	2,872,301			88.02
88.03	08803	RURAL HEALTH CLINIC IV - SPENCER	0	1,488,978	1,488,978			88.03
90.00	09000	CLINIC	30,710	904,220	934,930	1.442013	0.000000	90.00
90.01	09001	PAIN MANAGEMENT	0	0	0	0.000000	0.000000	90.01
90.02	09002	WOUND CARE	16,194	1,505,917	1,522,111	0.394754	0.000000	90.02
90.03	09003	ORTHOPEDIC CLINIC	0	782,478	782,478	0.165796	0.000000	90.03
91.00	09100	EMERGENCY	513,236	14,939,653	15,452,889	0.253721	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	32,125	865,720	897,845	1.673418	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	4,509,939	4,509,939	0.399908	0.000000	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0			102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0			116.00
200.00		Subtotal (see instructions)	16,920,369	108,663,017	125,583,386			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	16,920,369	108,663,017	125,583,386			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-1322 | Period: From 01/01/2022 To 12/31/2022 | Worksheet C Part I | Date/Time Prepared: 5/23/2023 1:34 pm

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
43.00	04300	NURSERY		43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
60.00	06000	LABORATORY	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC - TCC		88.00
88.01	08801	RURAL HEALTH CLINIC II - PCFP		88.01
88.02	08802	RURAL HEALTH CLINIC III - 13TH		88.02
88.03	08803	RURAL HEALTH CLINIC IV - SPENCER		88.03
90.00	09000	CLINIC	0.000000	90.00
90.01	09001	PAIN MANAGEMENT	0.000000	90.01
90.02	09002	WOUND CARE	0.000000	90.02
90.03	09003	ORTHOPEDIC CLINIC	0.000000	90.03
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
102.00	10200	OPIOID TREATMENT PROGRAM		102.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
116.00	11600	HOSPICE		116.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-1322 | Period: From 01/01/2022 To 12/31/2022 | Worksheet C Part I | Date/Time Prepared: 5/23/2023 1:34 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	9,997,082		9,997,082	0	9,997,082	30.00
31.00	03100	INTENSIVE CARE UNIT	0		0	0	0	31.00
43.00	04300	NURSERY	68,155		68,155	0	68,155	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,635,931		2,635,931	0	2,635,931	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	300,882		300,882	0	300,882	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,465,976		2,465,976	0	2,465,976	54.00
60.00	06000	LABORATORY	3,074,540		3,074,540	0	3,074,540	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	135,722		135,722	0	135,722	62.00
65.00	06500	RESPIRATORY THERAPY	1,661,452	0	1,661,452	0	1,661,452	65.00
66.00	06600	PHYSICAL THERAPY	1,025,165	0	1,025,165	0	1,025,165	66.00
67.00	06700	OCCUPATIONAL THERAPY	346,602	0	346,602	0	346,602	67.00
68.00	06800	SPEECH PATHOLOGY	207,663	0	207,663	0	207,663	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	874,103		874,103	0	874,103	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	136,531		136,531	0	136,531	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,568,029		4,568,029	0	4,568,029	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC - TCC	3,753,904		3,753,904	0	3,753,904	88.00
88.01	08801	RURAL HEALTH CLINIC II - PCFP	1,333,386		1,333,386	0	1,333,386	88.01
88.02	08802	RURAL HEALTH CLINIC III - 13TH	2,717,557		2,717,557	0	2,717,557	88.02
88.03	08803	RURAL HEALTH CLINIC IV - SPENCER	1,205,207		1,205,207	0	1,205,207	88.03
90.00	09000	CLINIC	1,348,181		1,348,181	0	1,348,181	90.00
90.01	09001	PAIN MANAGEMENT	0		0	0	0	90.01
90.02	09002	WOUND CARE	600,859		600,859	0	600,859	90.02
90.03	09003	ORTHOPEDIC CLINIC	129,732		129,732	0	129,732	90.03
91.00	09100	EMERGENCY	3,920,721		3,920,721	0	3,920,721	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,502,470		1,502,470		1,502,470	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,803,559		1,803,559	0	1,803,559	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0		0		0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0		0		0	116.00
200.00		Subtotal (see instructions)	45,813,409	0	45,813,409	0	45,813,409	200.00
201.00		Less Observation Beds	1,502,470		1,502,470		1,502,470	201.00
202.00		Total (see instructions)	44,310,939	0	44,310,939	0	44,310,939	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-1322 | Period: From 01/01/2022 To 12/31/2022 | Worksheet C Part I | Date/Time Prepared: 5/23/2023 1:34 pm

Title XIX | Hospital | PPS

		Cost Center Description	Charges Inpatient	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	5,374,008		5,374,008			30.00
31.00	03100	INTENSIVE CARE UNIT	0		0			31.00
43.00	04300	NURSERY	120,720		120,720			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	975,904	8,237,177	9,213,081	0.286107	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	529,008	122,023	651,031	0.462162	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	907,377	17,084,485	17,991,862	0.137061	0.000000	54.00
60.00	06000	LABORATORY	1,613,747	18,905,252	20,518,999	0.149839	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	54,878	378,844	433,722	0.312924	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	1,150,591	3,842,252	4,992,843	0.332767	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	654,276	2,361,787	3,016,063	0.339902	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	556,907	764,240	1,321,147	0.262349	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	163,228	507,730	670,958	0.309502	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,542,013	3,092,577	4,634,590	0.188604	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,312	206,913	208,225	0.655690	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,684,135	17,571,937	20,256,072	0.225514	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC - TCC	0	5,567,354	5,567,354	0.674271	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II - PCFP	0	2,151,240	2,151,240	0.619822	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III - 13TH	0	2,872,301	2,872,301	0.946125	0.000000	88.02
88.03	08803	RURAL HEALTH CLINIC IV - SPENCER	0	1,488,978	1,488,978	0.809419	0.000000	88.03
90.00	09000	CLINIC	30,710	904,220	934,930	1.442013	0.000000	90.00
90.01	09001	PAIN MANAGEMENT	0	0	0	0.000000	0.000000	90.01
90.02	09002	WOUND CARE	16,194	1,505,917	1,522,111	0.394754	0.000000	90.02
90.03	09003	ORTHOPEDIC CLINIC	0	782,478	782,478	0.165796	0.000000	90.03
91.00	09100	EMERGENCY	513,236	14,939,653	15,452,889	0.253721	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	32,125	865,720	897,845	1.673418	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	4,509,939	4,509,939	0.399908	0.000000	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0			102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0			116.00
200.00		Subtotal (see instructions)	16,920,369	108,663,017	125,583,386			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	16,920,369	108,663,017	125,583,386			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1322 | Period: From 01/01/2022 To 12/31/2022 | Worksheet C Part I Date/Time Prepared: 5/23/2023 1:34 pm

Title XIX | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
43.00	04300	NURSERY		43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.286107	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.462162	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.137061	54.00
60.00	06000	LABORATORY	0.149839	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.312924	62.00
65.00	06500	RESPIRATORY THERAPY	0.332767	65.00
66.00	06600	PHYSICAL THERAPY	0.339902	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.262349	67.00
68.00	06800	SPEECH PATHOLOGY	0.309502	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.188604	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.655690	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.225514	73.00
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC - TCC	0.674271	88.00
88.01	08801	RURAL HEALTH CLINIC II - PCFP	0.619822	88.01
88.02	08802	RURAL HEALTH CLINIC III - 13TH	0.946125	88.02
88.03	08803	RURAL HEALTH CLINIC IV - SPENCER	0.809419	88.03
90.00	09000	CLINIC	1.442013	90.00
90.01	09001	PAIN MANAGEMENT	0.000000	90.01
90.02	09002	WOUND CARE	0.394754	90.02
90.03	09003	ORTHOPEDIC CLINIC	0.165796	90.03
91.00	09100	EMERGENCY	0.253721	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.673418	92.00
		OTHER REIMBURSABLE COST CENTERS		
95.00	09500	AMBULANCE SERVICES	0.399908	95.00
102.00	10200	OPIOID TREATMENT PROGRAM		102.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
116.00	11600	HOSPICE		116.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

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

Provider CCN: 15-1322 | Period: From 01/01/2022 To 12/31/2022 | Worksheet C Part II | Date/Time Prepared: 5/23/2023 1:34 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	2,635,931	596,869	2,039,062	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	300,882	141,163	159,719	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,465,976	318,923	2,147,053	0	0	54.00
60.00	06000	LABORATORY	3,074,540	159,698	2,914,842	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	135,722	1,704	134,018	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	1,661,452	200,577	1,460,875	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,025,165	101,021	924,144	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	346,602	42,147	304,455	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	207,663	23,308	184,355	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	874,103	10,978	863,125	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	136,531	1,715	134,816	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,568,029	122,045	4,445,984	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC - TCC	3,753,904	49,186	3,704,718	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II - PCFP	1,333,386	17,405	1,315,981	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III - 13TH	2,717,557	35,826	2,681,731	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV - SPENCER	1,205,207	15,899	1,189,308	0	0	88.03
90.00	09000	CLINIC	1,348,181	227,781	1,120,400	0	0	90.00
90.01	09001	PAIN MANAGEMENT	0	0	0	0	0	90.01
90.02	09002	WOUND CARE	600,859	75,703	525,156	0	0	90.02
90.03	09003	ORTHOPEDIC CLINIC	129,732	1,717	128,015	0	0	90.03
91.00	09100	EMERGENCY	3,920,721	367,078	3,553,643	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,502,470	170,953	1,331,517	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,803,559	216,354	1,587,205	0	0	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
200.00		Subtotal (sum of lines 50 thru 199)	35,748,172	2,898,050	32,850,122	0	0	200.00
201.00		Less Observation Beds	1,502,470	170,953	1,331,517	0	0	201.00
202.00		Total (line 200 minus line 201)	34,245,702	2,727,097	31,518,605	0	0	202.00

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

Provider CCN: 15-1322

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

Worksheet C Part II

Date/Time Prepared: 5/23/2023 1:34 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	2,635,931	9,213,081	0.286107	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	300,882	651,031	0.462162	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,465,976	17,991,862	0.137061	54.00
60.00	06000	LABORATORY	3,074,540	20,518,999	0.149839	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	135,722	433,722	0.312924	62.00
65.00	06500	RESPIRATORY THERAPY	1,661,452	4,992,843	0.332767	65.00
66.00	06600	PHYSICAL THERAPY	1,025,165	3,016,063	0.339902	66.00
67.00	06700	OCCUPATIONAL THERAPY	346,602	1,321,147	0.262349	67.00
68.00	06800	SPEECH PATHOLOGY	207,663	670,958	0.309502	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	874,103	4,634,590	0.188604	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	136,531	208,225	0.655690	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,568,029	20,256,072	0.225514	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC - TCC	3,753,904	5,567,354	0.674271	88.00
88.01	08801	RURAL HEALTH CLINIC II - PCFP	1,333,386	2,151,240	0.619822	88.01
88.02	08802	RURAL HEALTH CLINIC III - 13TH	2,717,557	2,872,301	0.946125	88.02
88.03	08803	RURAL HEALTH CLINIC IV - SPENCER	1,205,207	1,488,978	0.809419	88.03
90.00	09000	CLINIC	1,348,181	934,930	1.442013	90.00
90.01	09001	PAIN MANAGEMENT	0	0	0.000000	90.01
90.02	09002	WOUND CARE	600,859	1,522,111	0.394754	90.02
90.03	09003	ORTHOPEDIC CLINIC	129,732	782,478	0.165796	90.03
91.00	09100	EMERGENCY	3,920,721	15,452,889	0.253721	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,502,470	897,845	1.673418	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	1,803,559	4,509,939	0.399908	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0.000000	102.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
116.00	11600	HOSPICE	0	0	0.000000	116.00
200.00		Subtotal (sum of lines 50 thru 199)	35,748,172	120,088,658		200.00
201.00		Less Observation Beds	1,502,470	0		201.00
202.00		Total (line 200 minus line 201)	34,245,702	120,088,658		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-1322 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part II Date/Time Prepared: 5/23/2023 1:34 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	596,869	9,213,081	0.064785	256,496	16,617	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	141,163	651,031	0.216830	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	318,923	17,991,862	0.017726	434,921	7,709	54.00
60.00	06000	LABORATORY	159,698	20,518,999	0.007783	667,340	5,194	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	1,704	433,722	0.003929	17,079	67	62.00
65.00	06500	RESPIRATORY THERAPY	200,577	4,992,843	0.040173	440,204	17,684	65.00
66.00	06600	PHYSICAL THERAPY	101,021	3,016,063	0.033494	193,392	6,477	66.00
67.00	06700	OCCUPATIONAL THERAPY	42,147	1,321,147	0.031902	148,405	4,734	67.00
68.00	06800	SPEECH PATHOLOGY	23,308	670,958	0.034738	50,280	1,747	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	10,978	4,634,590	0.002369	534,092	1,265	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,715	208,225	0.008236	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	122,045	20,256,072	0.006025	1,021,195	6,153	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC - TCC	49,186	5,567,354	0.008835	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II - PCFP	17,405	2,151,240	0.008091	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III - 13TH	35,826	2,872,301	0.012473	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV - SPENCER	15,899	1,488,978	0.010678	0	0	88.03
90.00	09000	CLINIC	227,781	934,930	0.243634	11,435	2,786	90.00
90.01	09001	PAIN MANAGEMENT	0	0	0.000000	0	0	90.01
90.02	09002	WOUND CARE	75,703	1,522,111	0.049736	12,706	632	90.02
90.03	09003	ORTHOPEDIC CLINIC	1,717	782,478	0.002194	0	0	90.03
91.00	09100	EMERGENCY	367,078	15,452,889	0.023755	35,982	855	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	170,953	897,845	0.190404	3,026	576	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	2,681,696	115,578,719		3,826,553	72,496	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1322

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

Worksheet D Part IV

Date/Time Prepared: 5/23/2023 1:34 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC - TCC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II - PCFP	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III - 13TH	0	0	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV - SPENCER	0	0	0	0	0	88.03
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	PAIN MANAGEMENT	0	0	0	0	0	90.01
90.02	09002	WOUND CARE	0	0	0	0	0	90.02
90.03	09003	ORTHOPEDIC CLINIC	0	0	0	0	0	90.03
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: 15-1322 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part IV | Date/Time Prepared: 5/23/2023 1:34 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	9,213,081	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	651,031	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	17,991,862	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	20,518,999	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	433,722	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	4,992,843	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	3,016,063	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,321,147	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	670,958	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	4,634,590	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	208,225	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	20,256,072	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC - TCC	0	0	0	5,567,354	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II - PCFP	0	0	0	2,151,240	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III - 13TH	0	0	0	2,872,301	0.000000	88.02
88.03	08803	RURAL HEALTH CLINIC IV - SPENCER	0	0	0	1,488,978	0.000000	88.03
90.00	09000	CLINIC	0	0	0	934,930	0.000000	90.00
90.01	09001	PAIN MANAGEMENT	0	0	0	0	0.000000	90.01
90.02	09002	WOUND CARE	0	0	0	1,522,111	0.000000	90.02
90.03	09003	ORTHOPEDIC CLINIC	0	0	0	782,478	0.000000	90.03
91.00	09100	EMERGENCY	0	0	0	15,452,889	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	897,845	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	115,578,719		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1322 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part IV | Date/Time Prepared: 5/23/2023 1:34 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	256,496	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	434,921	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	667,340	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	17,079	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.000000	440,204	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	193,392	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	148,405	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	50,280	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	534,092	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	1,021,195	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC - TCC	0.000000	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II - PCFP	0.000000	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III - 13TH	0.000000	0	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV - SPENCER	0.000000	0	0	0	0	88.03
90.00	09000	CLINIC	0.000000	11,435	0	0	0	90.00
90.01	09001	PAIN MANAGEMENT	0.000000	0	0	0	0	90.01
90.02	09002	WOUND CARE	0.000000	12,706	0	0	0	90.02
90.03	09003	ORTHOPEDIC CLINIC	0.000000	0	0	0	0	90.03
91.00	09100	EMERGENCY	0.000000	35,982	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	3,026	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		3,826,553	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1322 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part V Date/Time Prepared: 5/23/2023 1:34 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	0.286107	0	1,575,326	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.462162	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.137061	0	4,888,552	0	0	54.00
60.00	06000	LABORATORY	0.149839	0	2,818,555	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.312924	0	154,637	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.332767	0	871,906	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.339902	0	608,117	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.262349	0	137,922	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.309502	0	45,327	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.188604	0	718,118	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.655690	0	65,680	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.225514	0	8,504,920	4,829	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC - TCC						88.00
88.01	08801	RURAL HEALTH CLINIC II - PCFP						88.01
88.02	08802	RURAL HEALTH CLINIC III - 13TH						88.02
88.03	08803	RURAL HEALTH CLINIC IV - SPENCER						88.03
90.00	09000	CLINIC	1.442013	0	186,078	9,343	0	90.00
90.01	09001	PAIN MANAGEMENT	0.000000	0	0	0	0	90.01
90.02	09002	WOUND CARE	0.394754	0	800,546	0	0	90.02
90.03	09003	ORTHOPEDIC CLINIC	0.165796	0	0	0	0	90.03
91.00	09100	EMERGENCY	0.253721	0	3,191,017	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.673418	0	319,168	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.399908		0			95.00
200.00		Subtotal (see instructions)		0	24,885,869	14,172	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	24,885,869	14,172	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1322 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part V | Date/Time Prepared: 5/23/2023 1:34 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	450,712	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	670,030	0	54.00
60.00	06000	LABORATORY	422,329	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	48,390	0	62.00
65.00	06500	RESPIRATORY THERAPY	290,142	0	65.00
66.00	06600	PHYSICAL THERAPY	206,700	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	36,184	0	67.00
68.00	06800	SPEECH PATHOLOGY	14,029	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	135,440	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	43,066	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,917,979	1,089	73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC - TCC			88.00
88.01	08801	RURAL HEALTH CLINIC II - PCFP			88.01
88.02	08802	RURAL HEALTH CLINIC III - 13TH			88.02
88.03	08803	RURAL HEALTH CLINIC IV - SPENCER			88.03
90.00	09000	CLINIC	268,327	13,473	90.00
90.01	09001	PAIN MANAGEMENT	0	0	90.01
90.02	09002	WOUND CARE	316,019	0	90.02
90.03	09003	ORTHOPEDIC CLINIC	0	0	90.03
91.00	09100	EMERGENCY	809,628	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	534,101	0	92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0		95.00
200.00		Subtotal (see instructions)	6,163,076	14,562	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	6,163,076	14,562	202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-1322 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part I Date/Time Prepared: 5/23/2023 1:34 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	1,137,476	301,748	835,728	2,327	359.14	30.00
31.00	INTENSIVE CARE UNIT	0		0	0	0.00	31.00
43.00	NURSERY	31,977		31,977	119	268.71	43.00
200.00	Total (lines 30 through 199)	1,169,453		867,705	2,446		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	21	7,542	30.00
31.00	INTENSIVE CARE UNIT	0	0	31.00
43.00	NURSERY	0	0	43.00
200.00	Total (lines 30 through 199)	21	7,542	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-1322 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part II Date/Time Prepared: 5/23/2023 1:34 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	596,869	9,213,081	0.064785	162,196	10,508	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	141,163	651,031	0.216830	200,804	43,540	52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	318,923	17,991,862	0.017726	40,381	716	54.00
60.00 06000 LABORATORY	159,698	20,518,999	0.007783	100,902	785	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	1,704	433,722	0.003929	1,358	5	62.00
65.00 06500 RESPIRATORY THERAPY	200,577	4,992,843	0.040173	9,386	377	65.00
66.00 06600 PHYSICAL THERAPY	101,021	3,016,063	0.033494	3,147	105	66.00
67.00 06700 OCCUPATIONAL THERAPY	42,147	1,321,147	0.031902	2,839	91	67.00
68.00 06800 SPEECH PATHOLOGY	23,308	670,958	0.034738	5,032	175	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	10,978	4,634,590	0.002369	124,752	296	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	1,715	208,225	0.008236	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	122,045	20,256,072	0.006025	100,297	604	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC - TCC	49,186	5,567,354	0.008835	0	0	88.00
88.01 08801 RURAL HEALTH CLINIC II - PCFP	17,405	2,151,240	0.008091	0	0	88.01
88.02 08802 RURAL HEALTH CLINIC III - 13TH	35,826	2,872,301	0.012473	0	0	88.02
88.03 08803 RURAL HEALTH CLINIC IV - SPENCER	15,899	1,488,978	0.010678	0	0	88.03
90.00 09000 CLINIC	227,781	934,930	0.243634	3,087	752	90.00
90.01 09001 PAIN MANAGEMENT	0	0	0.000000	0	0	90.01
90.02 09002 WOUND CARE	75,703	1,522,111	0.049736	242	12	90.02
90.03 09003 ORTHOPEDIC CLINIC	1,717	782,478	0.002194	0	0	90.03
91.00 09100 EMERGENCY	367,078	15,452,889	0.023755	89,223	2,119	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	170,953	897,845	0.190404	3,738	712	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)	2,681,696	115,578,719		847,384	60,797	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1322 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part III Date/Time Prepared: 5/23/2023 1:34 pm

Title XIX | Hospital | PPS

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

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	2,327	0.00	21	30.00
31.00	03100	INTENSIVE CARE UNIT		0	0	0.00	0	31.00
43.00	04300	NURSERY		0	119	0.00	0	43.00
200.00		Total (lines 30 through 199)		0	2,446		21	200.00

		Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
			9.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	31.00
43.00	04300	NURSERY	0	43.00
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1322 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part IV | Date/Time Prepared: 5/23/2023 1:34 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
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC - TCC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II - PCFP	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III - 13TH	0	0	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV - SPENCER	0	0	0	0	0	88.03
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	PAIN MANAGEMENT	0	0	0	0	0	90.01
90.02	09002	WOUND CARE	0	0	0	0	0	90.02
90.03	09003	ORTHOPEDIC CLINIC	0	0	0	0	0	90.03
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: 15-1322 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part IV | Date/Time Prepared: 5/23/2023 1:34 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	9,213,081	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	651,031	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	17,991,862	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	20,518,999	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	433,722	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	4,992,843	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	3,016,063	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,321,147	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	670,958	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	4,634,590	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	208,225	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	20,256,072	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC - TCC	0	0	0	5,567,354	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II - PCFP	0	0	0	2,151,240	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III - 13TH	0	0	0	2,872,301	0.000000	88.02
88.03	08803	RURAL HEALTH CLINIC IV - SPENCER	0	0	0	1,488,978	0.000000	88.03
90.00	09000	CLINIC	0	0	0	934,930	0.000000	90.00
90.01	09001	PAIN MANAGEMENT	0	0	0	0	0.000000	90.01
90.02	09002	WOUND CARE	0	0	0	1,522,111	0.000000	90.02
90.03	09003	ORTHOPEDIC CLINIC	0	0	0	782,478	0.000000	90.03
91.00	09100	EMERGENCY	0	0	0	15,452,889	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	897,845	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	115,578,719		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1322 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part IV | Date/Time Prepared: 5/23/2023 1:34 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	162,196	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	200,804	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	40,381	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	100,902	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	1,358	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.000000	9,386	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	3,147	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	2,839	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	5,032	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	124,752	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	100,297	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC - TCC	0.000000	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II - PCFP	0.000000	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III - 13TH	0.000000	0	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV - SPENCER	0.000000	0	0	0	0	88.03
90.00	09000	CLINIC	0.000000	3,087	0	0	0	90.00
90.01	09001	PAIN MANAGEMENT	0.000000	0	0	0	0	90.01
90.02	09002	WOUND CARE	0.000000	242	0	0	0	90.02
90.03	09003	ORTHOPEDIC CLINIC	0.000000	0	0	0	0	90.03
91.00	09100	EMERGENCY	0.000000	89,223	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	3,738	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		847,384	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1322 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part V Date/Time Prepared: 5/23/2023 1:34 pm

Title XIX | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.286107	0	1,012,310	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.462162	0	37,826	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.137061	0	1,925,678	0	0	54.00
60.00	06000	LABORATORY	0.149839	0	2,206,381	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.312924	0	3,395	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.332767	0	413,306	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.339902	0	221,809	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.262349	0	101,073	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.309502	0	90,685	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.188604	0	417,328	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.655690	0	3,334	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.225514	0	2,306,914	0	0	73.00
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC - TCC						88.00
88.01	08801	RURAL HEALTH CLINIC II - PCFP						88.01
88.02	08802	RURAL HEALTH CLINIC III - 13TH						88.02
88.03	08803	RURAL HEALTH CLINIC IV - SPENCER						88.03
90.00	09000	CLINIC	1.442013	0	59,978	0	0	90.00
90.01	09001	PAIN MANAGEMENT	0.000000	0	0	0	0	90.01
90.02	09002	WOUND CARE	0.394754	0	142,698	0	0	90.02
90.03	09003	ORTHOPEDIC CLINIC	0.165796	0	0	0	0	90.03
91.00	09100	EMERGENCY	0.253721	0	2,438,078	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.673418	0	76,764	0	0	92.00
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0.399908	0	0			95.00
200.00		Subtotal (see instructions)		0	11,457,557	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	11,457,557	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1322 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part V Date/Time Prepared: 5/23/2023 1:34 pm

Title XIX | Hospital | PPS

		Cost Center Description	Costs		
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	289,629	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	17,482	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	263,935	0	54.00
60.00	06000	LABORATORY	330,602	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	1,062	0	62.00
65.00	06500	RESPIRATORY THERAPY	137,535	0	65.00
66.00	06600	PHYSICAL THERAPY	75,393	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	26,516	0	67.00
68.00	06800	SPEECH PATHOLOGY	28,067	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	78,710	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	2,186	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	520,241	0	73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC - TCC			88.00
88.01	08801	RURAL HEALTH CLINIC II - PCFP			88.01
88.02	08802	RURAL HEALTH CLINIC III - 13TH			88.02
88.03	08803	RURAL HEALTH CLINIC IV - SPENCER			88.03
90.00	09000	CLINIC	86,489	0	90.00
90.01	09001	PAIN MANAGEMENT	0	0	90.01
90.02	09002	WOUND CARE	56,331	0	90.02
90.03	09003	ORTHOPEDIC CLINIC	0	0	90.03
91.00	09100	EMERGENCY	618,592	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	128,458	0	92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0		95.00
200.00		Subtotal (see instructions)	2,661,228	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	2,661,228	0	202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1322 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-1 | Date/Time Prepared: 5/23/2023 1:34 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)	3,355	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,327	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,851	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	824	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	204	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)	974	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)	824	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	250.44	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	250.44	20.00
21.00	Total general inpatient routine service cost (see instructions)	9,997,082	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)	51,090	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)	2,652,013	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	7,345,069	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)	7,345,069	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)	3,156.46	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	3,074,392	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	3,074,392	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1322 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-1 | Date/Time Prepared: 5/23/2023 1:34 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	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	871,773	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)	3,946,165	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)	2,600,923	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	2,600,923	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)	476	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	3,156.45	88.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-1322	Period: From 01/01/2022 To 12/31/2022	Worksheet D-1 Date/Time Prepared: 5/23/2023 1:34 pm
	Title XVIII	Hospital	Cost

	Cost Center Description	1.00	
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,502,470	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	1,137,476	9,997,082	0.113781	1,502,470	170,953	90.00
91.00	Nursing Program cost	0	9,997,082	0.000000	1,502,470	0	91.00
92.00	Allied health cost	0	9,997,082	0.000000	1,502,470	0	92.00
93.00	All other Medical Education	0	9,997,082	0.000000	1,502,470	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1322 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-1 | Date/Time Prepared: 5/23/2023 1:34 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)	3,355	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,327	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,851	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	824	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	204	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)	21	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)	119	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	250.44	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	250.44	20.00
21.00	Total general inpatient routine service cost (see instructions)	9,997,082	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)	51,090	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)	2,652,013	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	7,345,069	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)	7,345,069	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)	3,156.45	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	66,285	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)	66,285	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1322 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-1 | Date/Time Prepared: 5/23/2023 1:34 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)	68,155	119	572.73	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description	1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	246,370	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)	312,655	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)	7,542	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	60,797	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	68,339	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	244,316	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)	476	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	3,156.45	88.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1322 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-1 | Date/Time Prepared: 5/23/2023 1:34 pm

Title XIX | Hospital | PPS

	Cost Center Description	1.00	
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,502,470	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	1,137,476	9,997,082	0.113781	1,502,470	170,953	90.00
91.00	Nursing Program cost	0	9,997,082	0.000000	1,502,470	0	91.00
92.00	Allied health cost	0	9,997,082	0.000000	1,502,470	0	92.00
93.00	All other Medical Education	0	9,997,082	0.000000	1,502,470	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1322 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-3 | Date/Time Prepared: 5/23/2023 1:34 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		1,660,008		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.286107	256,496	73,385	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.462162	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.137061	434,921	59,611	54.00
60.00	06000	LABORATORY	0.149839	667,340	99,994	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.312924	17,079	5,344	62.00
65.00	06500	RESPIRATORY THERAPY	0.332767	440,204	146,485	65.00
66.00	06600	PHYSICAL THERAPY	0.339902	193,392	65,734	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.262349	148,405	38,934	67.00
68.00	06800	SPEECH PATHOLOGY	0.309502	50,280	15,562	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.188604	534,092	100,732	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.655690	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.225514	1,021,195	230,294	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC - TCC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II - PCFP	0.000000		0	88.01
88.02	08802	RURAL HEALTH CLINIC III - 13TH	0.000000		0	88.02
88.03	08803	RURAL HEALTH CLINIC IV - SPENCER	0.000000		0	88.03
90.00	09000	CLINIC	1.442013	11,435	16,489	90.00
90.01	09001	PAIN MANAGEMENT	0.000000	0	0	90.01
90.02	09002	WOUND CARE	0.394754	12,706	5,016	90.02
90.03	09003	ORTHOPEDIC CLINIC	0.165796	0	0	90.03
91.00	09100	EMERGENCY	0.253721	35,982	9,129	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.673418	3,026	5,064	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)		3,826,553	871,773	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)		3,826,553		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 15-1322 Component CCN: 15-Z322	Period: From 01/01/2022 To 12/31/2022	Worksheet D-3 Date/Time Prepared: 5/23/2023 1:34 pm
	Title XVIII	Swing Beds - SNF	Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.286107	2,573	736	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.462162	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.137061	5,923	812	54.00
60.00	06000	LABORATORY	0.149839	117,185	17,559	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.312924	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.332767	156,644	52,126	65.00
66.00	06600	PHYSICAL THERAPY	0.339902	322,671	109,677	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.262349	298,288	78,256	67.00
68.00	06800	SPEECH PATHOLOGY	0.309502	72,702	22,501	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.188604	166,123	31,331	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.655690	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.225514	240,592	54,257	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC - TCC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II - PCFP	0.000000		0	88.01
88.02	08802	RURAL HEALTH CLINIC III - 13TH	0.000000		0	88.02
88.03	08803	RURAL HEALTH CLINIC IV - SPENCER	0.000000		0	88.03
90.00	09000	CLINIC	1.442013	798	1,151	90.00
90.01	09001	PAIN MANAGEMENT	0.000000	0	0	90.01
90.02	09002	WOUND CARE	0.394754	218	86	90.02
90.03	09003	ORTHOPEDIC CLINIC	0.165796	0	0	90.03
91.00	09100	EMERGENCY	0.253721	270	69	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.673418	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)		1,383,987	368,561	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		1,383,987		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1322 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-3 | Date/Time Prepared: 5/23/2023 1:34 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		149,544		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
43.00	04300	NURSERY		10,060		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.286107	162,196	46,405	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.462162	200,804	92,804	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.137061	40,381	5,535	54.00
60.00	06000	LABORATORY	0.149839	100,902	15,119	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.312924	1,358	425	62.00
65.00	06500	RESPIRATORY THERAPY	0.332767	9,386	3,123	65.00
66.00	06600	PHYSICAL THERAPY	0.339902	3,147	1,070	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.262349	2,839	745	67.00
68.00	06800	SPEECH PATHOLOGY	0.309502	5,032	1,557	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.188604	124,752	23,529	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.655690	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.225514	100,297	22,618	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC - TCC	0.674271	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II - PCFP	0.619822	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III - 13TH	0.946125	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV - SPENCER	0.809419	0	0	88.03
90.00	09000	CLINIC	1.442013	3,087	4,451	90.00
90.01	09001	PAIN MANAGEMENT	0.000000	0	0	90.01
90.02	09002	WOUND CARE	0.394754	242	96	90.02
90.03	09003	ORTHOPEDIC CLINIC	0.165796	0	0	90.03
91.00	09100	EMERGENCY	0.253721	89,223	22,638	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.673418	3,738	6,255	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)		847,384	246,370	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)		847,384		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-1322 | Period: From 01/01/2022 To 12/31/2022 | Worksheet E Part B Date/Time Prepared: 5/23/2023 1:34 pm

Title XVIII | Hospital | Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	6,177,638	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)	6,177,638	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)	6,239,414	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)	61,949	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	4,353,141	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)	1,824,324	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)	1,824,324	30.00
31.00	Primary payer payments	597	31.00
32.00	Subtotal (line 30 minus line 31)	1,823,727	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)	429,422	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	279,124	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	294,585	36.00
37.00	Subtotal (see instructions)	2,102,851	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)	2,102,851	40.00
40.01	Sequestration adjustment (see instructions)	26,496	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	2,345,093	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)	-268,738	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	150,298	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: 15-1322	Period: From 01/01/2022 To 12/31/2022	Worksheet E Part B Date/Time Prepared: 5/23/2023 1:34 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: 15-1322 | Period: From 01/01/2022 To 12/31/2022 | Worksheet E-1 Part I Date/Time Prepared: 5/23/2023 1:34 pm

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		3,185,270		2,345,093	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	10/18/2022	166,700		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)		166,700		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		3,351,970		2,345,093	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		328,451		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		268,738	6.02
7.00	Total Medicare program liability (see instructions)		3,680,421		2,076,355	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: 15-1322 | Component CCN: 15-Z322 | Period: From 01/01/2022 To 12/31/2022 | Worksheet E-1 Part I | Date/Time Prepared: 5/23/2023 1:34 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		2,542,014		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	10/18/2022	113,900		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)		113,900		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)		2,655,914		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		303,746		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		2,959,660		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: 15-1322	Period: From 01/01/2022 To 12/31/2022	Worksheet E-1 Part II Date/Time Prepared: 5/23/2023 1:34 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: 15-1322 | Component CCN: 15-Z322 | Period: From 01/01/2022 To 12/31/2022 | Worksheet E-2 | Date/Time Prepared: 5/23/2023 1:34 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)	2,626,932	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)	372,247	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	824	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)	2,999,179	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	2,999,179	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)	2,999,179	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	1,751	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (see instructions)	2,997,428	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)	2,997,428	0	19.00
19.01	Sequestration adjustment (see instructions)	37,768	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	2,655,914	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)	303,746	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: 15-1322 | Period: From 01/01/2022 To 12/31/2022 | Worksheet E-3 Part V Date/Time Prepared: 5/23/2023 1:34 pm

Title XVIII | Hospital | Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	3,946,165	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)	3,946,165	4.00
5.00	Primary payer payments	10,437	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	3,975,190	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	3,975,190	19.00
20.00	Deductibles (exclude professional component)	267,560	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	3,707,630	22.00
23.00	Coinsurance	3,112	23.00
24.00	Subtotal (line 22 minus line 23)	3,704,518	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	35,182	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	22,868	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	17,790	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	3,727,386	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29.98	Recovery of accelerated depreciation.	0	29.98
29.99	Demonstration payment adjustment amount before sequestration	0	29.99
30.00	Subtotal (see instructions)	3,727,386	30.00
30.01	Sequestration adjustment (see instructions)	46,965	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
30.03	Sequestration adjustment-PARHM or CHART		30.03
31.00	Interim payments	3,351,970	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)	328,451	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	12,314	34.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only)

Provider CCN: 15-1322 | Period: From 01/01/2022 To 12/31/2022 | Worksheet G | Date/Time Prepared: 5/23/2023 1:34 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	14,978,506	0	0	0	1.00
2.00	Temporary investments	3,711,019	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	14,628,710	0	0	0	4.00
5.00	Other receivable	957,930	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-8,958,643	0	0	0	6.00
7.00	Inventory	756,012	0	0	0	7.00
8.00	Prepaid expenses	302,790	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	1,820,000	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	28,196,324	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	3,693,378	0	0	0	12.00
13.00	Land improvements	45,658	0	0	0	13.00
14.00	Accumulated depreciation	-15,463,195	0	0	0	14.00
15.00	Buildings	44,036,233	0	0	0	15.00
16.00	Accumulated depreciation	-2,817,288	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	2,606,705	0	0	0	19.00
20.00	Accumulated depreciation	-187,015	0	0	0	20.00
21.00	Automobiles and trucks	477,834	0	0	0	21.00
22.00	Accumulated depreciation	-477,834	0	0	0	22.00
23.00	Major movable equipment	19,305,090	0	0	0	23.00
24.00	Accumulated depreciation	-10,324,062	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)	40,895,504	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)	69,091,828	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1,644,732	0	0	0	37.00
38.00	Salaries, wages, and fees payable	0	0	0	0	38.00
39.00	Payroll taxes payable	705,520	0	0	0	39.00
40.00	Notes and loans payable (short term)	1,116,429	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	2,909,158	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	6,375,839	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	34,635,000	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	34,635,000	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	41,010,839	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	28,080,989				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)	28,080,989	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	69,091,828	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 15-1322 | Period: From 01/01/2022 To 12/31/2022 | Worksheet G-1 | Date/Time Prepared: 5/23/2023 1:34 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		28,823,648		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-396,065				2.00
3.00	Total (sum of line 1 and line 2)		28,427,583		0		3.00
4.00	FREESTANDING HOME HEALTH	-346,594		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)		-346,594		0		10.00
11.00	Subtotal (line 3 plus line 10)		28,080,989		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		28,080,989		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	FREESTANDING HOME HEALTH		0		4.00
5.00			0		5.00
6.00			0		6.00
7.00			0		7.00
8.00			0		8.00
9.00			0		9.00
10.00	Total additions (sum of line 4-9)	0		0	10.00
11.00	Subtotal (line 3 plus line 10)	0		0	11.00
12.00	Deductions (debit adjustments) (specify)		0		12.00
13.00			0		13.00
14.00			0		14.00
15.00			0		15.00
16.00			0		16.00
17.00			0		17.00
18.00	Total deductions (sum of lines 12-17)	0		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0	19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 15-1322 | Period: From 01/01/2022 To 12/31/2022 | Worksheet G-2 Parts I & II Date/Time Prepared: 5/23/2023 1:34 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	5,594,833		5,594,833	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	5,594,833		5,594,833	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	0		0	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)	5,594,833		5,594,833	17.00
18.00	Ancillary services	11,301,336	92,467,504	103,768,840	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC - TCC	0	5,567,354	5,567,354	20.00
20.01	RURAL HEALTH CLINIC II - PCFP	0	2,151,240	2,151,240	20.01
20.02	RURAL HEALTH CLINIC III - 13TH	0	2,872,301	2,872,301	20.02
20.03	RURAL HEALTH CLINIC IV - SPENCER	0	1,488,978	1,488,978	20.03
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	4,509,939	4,509,939	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE	0	0	0	26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	16,896,169	109,057,316	125,953,485	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		47,408,316		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		47,408,316		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 15-1322	Period: From 01/01/2022 To 12/31/2022	Worksheet G-3 Date/Time Prepared: 5/23/2023 1:34 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	125,953,485	1.00
2.00	Less contractual allowances and discounts on patients' accounts	83,010,802	2.00
3.00	Net patient revenues (line 1 minus line 2)	42,942,683	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	47,408,316	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-4,465,633	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	296,026	6.00
7.00	Income from investments	-144,261	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	161,709	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	65,036	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	54,954	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER OPERATING INCOME	2,643,468	24.00
24.50	COVID-19 PHE Funding	992,636	24.50
25.00	Total other income (sum of lines 6-24)	4,069,568	25.00
26.00	Total (line 5 plus line 25)	-396,065	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-396,065	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1322 | Component CCN: 15-8516 | Period: From 01/01/2022 To 12/31/2022 | Worksheet M-1 | Date/Time Prepared: 5/23/2023 1:34 pm

RHC I | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	1,093,029	0	1,093,029	-47,616	1,045,413	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	240,123	0	240,123	0	240,123	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	151,607	0	151,607	0	151,607	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	189,895	0	189,895	0	189,895	9.00
10.00	Subtotal (sum of lines 1 through 9)	1,674,654	0	1,674,654	-47,616	1,627,038	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	143,109	143,109	0	143,109	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	143,109	143,109	0	143,109	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,674,654	143,109	1,817,763	-47,616	1,770,147	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	45,035	45,035	0	45,035	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	45,035	45,035	0	45,035	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	0	0	0	0	29.00
30.00	Administrative Costs	196,778	1,035,374	1,232,152	0	1,232,152	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	196,778	1,035,374	1,232,152	0	1,232,152	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,871,432	1,223,518	3,094,950	-47,616	3,047,334	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1322 | Component CCN: 15-8516 | Period: From 01/01/2022 To 12/31/2022 | Worksheet M-1 | Date/Time Prepared: 5/23/2023 1:34 pm

RHC I | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
	FACILITY HEALTH CARE STAFF COSTS			
1.00	Physician	0	1,045,413	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	0	240,123	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	151,607	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	189,895	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	1,627,038	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	143,109	15.00
16.00	Transportation (Health Care Staff)	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	17.00
18.00	Professional Liability Insurance	0	0	18.00
19.00	Other Health Care Costs	0	0	19.00
20.00	Allowable GME Costs			20.00
21.00	Subtotal (sum of lines 15 through 20)	0	143,109	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	1,770,147	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES			
23.00	Pharmacy	0	45,035	23.00
24.00	Dental	0	0	24.00
25.00	Optometry	0	0	25.00
25.01	Telehealth	0	0	25.01
25.02	Chronic Care Management	0	0	25.02
26.00	All other nonreimbursable costs	0	0	26.00
27.00	Nonallowable GME costs			27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	45,035	28.00
	FACILITY OVERHEAD			
29.00	Facility Costs	0	0	29.00
30.00	Administrative Costs	0	1,232,152	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	1,232,152	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	3,047,334	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1322 | Period: From 01/01/2022 To 12/31/2022 | Worksheet M-1

Component CCN: 15-8517 | Date/Time Prepared: 5/23/2023 1:34 pm

RHC II | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	404,070	0	404,070	-111,777	292,293	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	0	0	0	111,389	111,389	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	2,690	0	2,690	0	2,690	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	131,134	0	131,134	0	131,134	9.00
10.00	Subtotal (sum of lines 1 through 9)	537,894	0	537,894	-388	537,506	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	38,028	38,028	0	38,028	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	38,028	38,028	0	38,028	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	537,894	38,028	575,922	-388	575,534	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	118,683	118,683	0	118,683	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	118,683	118,683	0	118,683	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	0	0	0	0	29.00
30.00	Administrative Costs	50,138	340,127	390,265	0	390,265	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	50,138	340,127	390,265	0	390,265	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	588,032	496,838	1,084,870	-388	1,084,482	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1322 | Component CCN: 15-8517 | Period: From 01/01/2022 To 12/31/2022 | Worksheet M-1 | Date/Time Prepared: 5/23/2023 1:34 pm

RHC II | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
	FACILITY HEALTH CARE STAFF COSTS			
1.00	Physician	0	292,293	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	0	111,389	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	2,690	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	131,134	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	537,506	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	38,028	15.00
16.00	Transportation (Health Care Staff)	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	17.00
18.00	Professional Liability Insurance	0	0	18.00
19.00	Other Health Care Costs	0	0	19.00
20.00	Allowable GME Costs			20.00
21.00	Subtotal (sum of lines 15 through 20)	0	38,028	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	575,534	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES			
23.00	Pharmacy	0	118,683	23.00
24.00	Dental	0	0	24.00
25.00	Optometry	0	0	25.00
25.01	Telehealth	0	0	25.01
25.02	Chronic Care Management	0	0	25.02
26.00	All other nonreimbursable costs	0	0	26.00
27.00	Nonallowable GME costs			27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	118,683	28.00
	FACILITY OVERHEAD			
29.00	Facility Costs	0	0	29.00
30.00	Administrative Costs	0	390,265	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	390,265	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	1,084,482	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1322 | Component CCN: 15-8560 | Period: From 01/01/2022 To 12/31/2022 | Worksheet M-1 | Date/Time Prepared: 5/23/2023 1:34 pm

RHC III | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	1,363,497	0	1,363,497	-170,521	1,192,976	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	0	0	0	62,271	62,271	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	123,284	0	123,284	0	123,284	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	95,084	0	95,084	0	95,084	9.00
10.00	Subtotal (sum of lines 1 through 9)	1,581,865	0	1,581,865	-108,250	1,473,615	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	48,839	48,839	0	48,839	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	48,839	48,839	0	48,839	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,581,865	48,839	1,630,704	-108,250	1,522,454	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	84,251	84,251	0	84,251	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	84,251	84,251	0	84,251	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	0	0	0	0	29.00
30.00	Administrative Costs	52,880	539,797	592,677	0	592,677	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	52,880	539,797	592,677	0	592,677	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,634,745	672,887	2,307,632	-108,250	2,199,382	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1322 | Period: From 01/01/2022 To 12/31/2022 | Worksheet M-1

Component CCN: 15-8560 | Date/Time Prepared: 5/23/2023 1:34 pm

RHC III | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
	FACILITY HEALTH CARE STAFF COSTS			
1.00	Physician	0	1,192,976	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	0	62,271	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	123,284	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	95,084	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	1,473,615	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	48,839	15.00
16.00	Transportation (Health Care Staff)	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	17.00
18.00	Professional Liability Insurance	0	0	18.00
19.00	Other Health Care Costs	0	0	19.00
20.00	Allowable GME Costs			20.00
21.00	Subtotal (sum of lines 15 through 20)	0	48,839	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	1,522,454	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES			
23.00	Pharmacy	0	84,251	23.00
24.00	Dental	0	0	24.00
25.00	Optometry	0	0	25.00
25.01	Telehealth	0	0	25.01
25.02	Chronic Care Management	0	0	25.02
26.00	All other nonreimbursable costs	0	0	26.00
27.00	Nonallowable GME costs			27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	84,251	28.00
	FACILITY OVERHEAD			
29.00	Facility Costs	0	0	29.00
30.00	Administrative Costs	-259	592,418	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-259	592,418	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-259	2,199,123	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1322 | Period: From 01/01/2022 To 12/31/2022 | Worksheet M-1

Component CCN: 15-8562 | Date/Time Prepared: 5/23/2023 1:34 pm

RHC IV | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	401,412	0	401,412	12,215	413,627	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	0	0	0	52,377	52,377	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	125,376	0	125,376	0	125,376	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	29,064	0	29,064	0	29,064	9.00
10.00	Subtotal (sum of lines 1 through 9)	555,852	0	555,852	64,592	620,444	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	6,647	6,647	0	6,647	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	6,647	6,647	0	6,647	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	555,852	6,647	562,499	64,592	627,091	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	26,519	26,519	0	26,519	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	26,519	26,519	0	26,519	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	0	0	0	0	29.00
30.00	Administrative Costs	60,078	261,275	321,353	0	321,353	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	60,078	261,275	321,353	0	321,353	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	615,930	294,441	910,371	64,592	974,963	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1322 | Component CCN: 15-8562 | Period: From 01/01/2022 To 12/31/2022 | Worksheet M-1 | Date/Time Prepared: 5/23/2023 1:34 pm

RHC IV | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
	FACILITY HEALTH CARE STAFF COSTS			
1.00	Physician	0	413,627	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	0	52,377	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	125,376	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	29,064	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	620,444	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	6,647	15.00
16.00	Transportation (Health Care Staff)	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	17.00
18.00	Professional Liability Insurance	0	0	18.00
19.00	Other Health Care Costs	0	0	19.00
20.00	Allowable GME Costs			20.00
21.00	Subtotal (sum of lines 15 through 20)	0	6,647	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	627,091	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES			
23.00	Pharmacy	0	26,519	23.00
24.00	Dental	0	0	24.00
25.00	Optometry	0	0	25.00
25.01	Telehealth	0	0	25.01
25.02	Chronic Care Management	0	0	25.02
26.00	All other nonreimbursable costs	0	0	26.00
27.00	Nonallowable GME costs			27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	26,519	28.00
	FACILITY OVERHEAD			
29.00	Facility Costs	0	0	29.00
30.00	Administrative Costs	0	321,353	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	321,353	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	974,963	32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES | Provider CCN: 15-1322 | Component CCN: 15-8516 | Period: From 01/01/2022 To 12/31/2022 | Worksheet M-2 | Date/Time Prepared: 5/23/2023 1:34 pm

RHC I | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.68	5,217	4,200	2,856		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	1.68	3,658	2,100	3,528		3.00
4.00	Subtotal (sum of lines 1 through 3)	2.36	8,875		6,384	8,875	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	2.36	8,875			8,875	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)	1,770,147	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)	45,035	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)	1,815,182	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)	0.975190	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)	1,232,152	14.00
15.00	Parent provider overhead allocated to facility (see instructions)	706,570	15.00
16.00	Total overhead (sum of lines 14 and 15)	1,938,722	16.00
17.00	Allowable GME overhead (see instructions)	0	17.00
18.00	Enter the amount from line 16	1,938,722	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)	1,890,622	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)	3,660,769	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 15-1322 Component CCN: 15-8517	Period: From 01/01/2022 To 12/31/2022	Worksheet M-2 Date/Time Prepared: 5/23/2023 1:34 pm
		RHC II	Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.67	1,646	4,200	2,814		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	0.70	861	2,100	1,470		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.37	2,507		4,284	4,284	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	1.37	2,507			4,284	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)	575,534	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)	118,683	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)	694,217	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)	0.829040	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)	390,265	14.00
15.00	Parent provider overhead allocated to facility (see instructions)	248,904	15.00
16.00	Total overhead (sum of lines 14 and 15)	639,169	16.00
17.00	Allowable GME overhead (see instructions)	0	17.00
18.00	Enter the amount from line 16	639,169	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)	529,897	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)	1,105,431	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES | Provider CCN: 15-1322 | Component CCN: 15-8560 | Period: From 01/01/2022 To 12/31/2022 | Worksheet M-2 | Date/Time Prepared: 5/23/2023 1:34 pm

RHC III | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	2.43	4,737	4,200	10,206		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	0.25	619	2,100	525		3.00
4.00	Subtotal (sum of lines 1 through 3)	2.68	5,356		10,731	10,731	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	2.68	5,356			10,731	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)	1,522,454	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)	84,251	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)	1,606,705	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)	0.947563	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)	592,418	14.00
15.00	Parent provider overhead allocated to facility (see instructions)	518,434	15.00
16.00	Total overhead (sum of lines 14 and 15)	1,110,852	16.00
17.00	Allowable GME overhead (see instructions)	0	17.00
18.00	Enter the amount from line 16	1,110,852	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)	1,052,602	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)	2,575,056	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES | Provider CCN: 15-1322 | Component CCN: 15-8562 | Period: From 01/01/2022 To 12/31/2022 | Worksheet M-2 | Date/Time Prepared: 5/23/2023 1:34 pm

RHC IV | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	1.36	4,152	4,200	5,712		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	0.03	262	2,100	63		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.39	4,414		5,775	5,775	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	1.39	4,414			5,775	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)	627,091	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)	26,519	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)	653,610	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)	0.959427	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)	321,353	14.00
15.00	Parent provider overhead allocated to facility (see instructions)	230,244	15.00
16.00	Total overhead (sum of lines 14 and 15)	551,597	16.00
17.00	Allowable GME overhead (see instructions)	0	17.00
18.00	Enter the amount from line 16	551,597	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)	529,217	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)	1,156,308	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 15-1322 Component CCN: 15-8516	Period: From 01/01/2022 To 12/31/2022	Worksheet M-3 Date/Time Prepared: 5/23/2023 1:34 pm
	Title XVIII	RHC I	Cost

			1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)		3,660,769	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)		58,569	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)		3,602,200	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		8,875	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)		8,875	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		405.88	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	225.59	8.00
9.00	Rate for Program covered visits (see instructions)	0.00	225.59	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	2,331	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	525,850	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	525,850	16.00
16.01	Total program charges (see instructions)(from contractor's records)		614,594	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		98,121	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		83,953	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.)		319,575	16.04
16.05	Total program cost (see instructions)	0	403,528	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		42,428	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		94,810	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		403,528	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		15,054	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		418,582	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)		418,582	26.00
26.01	Sequestration adjustment (see instructions)		5,274	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		395,893	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)		17,415	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: 15-1322 Component CCN: 15-8517	Period: From 01/01/2022 To 12/31/2022	Worksheet M-3 Date/Time Prepared: 5/23/2023 1:34 pm
	Title XVIII	RHC II	Cost

			1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)		1,105,431	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)		173,178	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)		932,253	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		4,284	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)		4,284	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		217.61	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	162.77	8.00
9.00	Rate for Program covered visits (see instructions)	0.00	162.77	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	147	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	23,927	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	23,927	16.00
16.01	Total program charges (see instructions)(from contractor's records)		41,882	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		15,649	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		8,940	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.)		9,632	16.04
16.05	Total program cost (see instructions)	0	18,572	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		2,947	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		4,657	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		18,572	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		2,565	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		21,137	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)		21,137	26.00
26.01	Sequestration adjustment (see instructions)		266	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		17,810	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)		3,061	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: 15-1322 Component CCN: 15-8560	Period: From 01/01/2022 To 12/31/2022	Worksheet M-3 Date/Time Prepared: 5/23/2023 1:34 pm
	Title XVIII	RHC III	Cost

		1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES		
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)	2,575,056	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)	134,602	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)	2,440,454	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)	10,731	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)	10,731	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)	227.42	7.00

		Calculation of Limit (1)		
		Rate Period N/A	Rate Period 1 (01/01/2022 through 12/31/2022)	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	0.00	113.00	8.00
9.00	Rate for Program covered visits (see instructions)	0.00	113.00	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	511	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	57,743	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	57,743	16.00
16.01	Total program charges (see instructions)(from contractor's records)		123,027	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		3,799	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		1,783	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		36,586	16.04
16.05	Total program cost (see instructions)	0	38,369	16.05
17.00	Primary payer amounts		178	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		10,228	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		21,800	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		38,191	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		1,714	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		39,905	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)		39,905	26.00
26.01	Sequestration adjustment (see instructions)		503	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		36,867	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)		2,535	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: 15-1322 Component CCN: 15-8562	Period: From 01/01/2022 To 12/31/2022	Worksheet M-3 Date/Time Prepared: 5/23/2023 1:34 pm
	Title XVIII	RHC IV	Cost

			1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)		1,156,308	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)		85,669	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)		1,070,639	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		5,775	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)		0	5.00
6.00	Total adjusted visits (line 4 plus line 5)		5,775	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		185.39	7.00
		Calculation of Limit (1)		
		Rate Period N/A	Rate Period 1 (01/01/2022 through 12/31/2022)	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	0.00	113.00	8.00
9.00	Rate for Program covered visits (see instructions)	0.00	113.00	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	976	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	110,288	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	110,288	16.00
16.01	Total program charges (see instructions)(from contractor's records)		236,331	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		6,181	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		2,884	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.)		58,261	16.04
16.05	Total program cost (see instructions)	0	61,145	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		34,578	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		39,115	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		61,145	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		20,954	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		82,099	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)		82,099	26.00
26.01	Sequestration adjustment (see instructions)		1,034	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		57,178	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)		23,887	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: 15-1322 Component CCN: 15-8516	Period: From 01/01/2022 To 12/31/2022	Worksheet M-4 Date/Time Prepared: 5/23/2023 1:34 pm
	Title XVIII	RHC I	Cost

		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	1,627,038	1,627,038	1,627,038	1,627,038	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.001256	0.006621	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	2,044	10,773	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	7,704	7,800	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	9,748	18,573	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	1,770,147	1,770,147	1,770,147	1,770,147	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	1,890,622	1,890,622	1,890,622	1,890,622	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.005507	0.010492	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	10,412	19,836	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	20,160	38,409	0	0	10.00
11.00	Total number of injections/infusions (from your records)	37	195	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	544.86	196.97	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	11	46	0	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	5,993	9,061	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)		58,569	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)		15,054	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 15-1322 | Component CCN: 15-8517 | Period: From 01/01/2022 To 12/31/2022 | Worksheet M-4 | Date/Time Prepared: 5/23/2023 1:34 pm

Title XVIII | RHC II | Cost

		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	537,506	537,506	537,506	537,506	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.015380	0.017310	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	8,267	9,304	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	60,753	11,840	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	69,020	21,144	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	575,534	575,534	575,534	575,534	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	529,897	529,897	529,897	529,897	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.119923	0.036738	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	63,547	19,467	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	132,567	40,611	0	0	10.00
11.00	Total number of injections/infusions (from your records)	263	296	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	504.06	137.20	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	4	4	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)	2,016	549	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)		173,178	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)		2,565	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST	Provider CCN: 15-1322 Component CCN: 15-8560	Period: From 01/01/2022 To 12/31/2022	Worksheet M-4 Date/Time Prepared: 5/23/2023 1:34 pm
	Title XVIII	RHC III	Cost

		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	1,473,615	1,473,615	1,473,615	1,473,615	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.008133	0.003678	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	11,985	5,420	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	57,256	4,920	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	69,241	10,340	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	1,522,454	1,522,454	1,522,454	1,522,454	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	1,052,602	1,052,602	1,052,602	1,052,602	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.045480	0.006792	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	47,872	7,149	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	117,113	17,489	0	0	10.00
11.00	Total number of injections/infusions (from your records)	272	123	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	430.56	142.19	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	2	6	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)	861	853	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)		134,602	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)		1,714	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 15-1322 | Component CCN: 15-8562 | Period: From 01/01/2022 To 12/31/2022 | Worksheet M-4 | Date/Time Prepared: 5/23/2023 1:34 pm

Title XVIII | RHC IV | Cost

		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	620,444	620,444	620,444	620,444	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.004670	0.018909	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	2,897	11,732	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	18,711	13,120	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	21,608	24,852	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	627,091	627,091	627,091	627,091	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	529,217	529,217	529,217	529,217	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.034458	0.039631	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	18,236	20,973	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	39,844	45,825	0	0	10.00
11.00	Total number of injections/infusions (from your records)	81	328	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	491.90	139.71	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	23	69	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)	11,314	9,640	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)		85,669	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)		20,954	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 15-1322 Component CCN: 15-8516	Period: From 01/01/2022 To 12/31/2022	Worksheet M-5 Date/Time Prepared: 5/23/2023 1:34 pm
		RHC I	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		395,893	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)		395,893	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		17,415	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		413,308	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: 15-1322 | Component CCN: 15-8517 | Period: From 01/01/2022 To 12/31/2022 | Worksheet M-5 | Date/Time Prepared: 5/23/2023 1:34 pm

RHC II | Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		17,810	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)		17,810	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		3,061	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		20,871	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: 15-1322 | Component CCN: 15-8560 | Period: From 01/01/2022 To 12/31/2022 | Worksheet M-5 | Date/Time Prepared: 5/23/2023 1:34 pm

RHC III | Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		36,867	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)		36,867	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		2,535	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		39,402	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: 15-1322 Component CCN: 15-8562	Period: From 01/01/2022 To 12/31/2022	Worksheet M-5 Date/Time Prepared: 5/23/2023 1:34 pm
		RHC IV	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		57,178	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)		57,178	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		23,887	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		81,065	7.00

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