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: 15-1313	Period: From 01/01/2022 To 12/31/2022	Worksheet S Parts I-III Date/Time Prepared: 5/26/2023 7:17 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 5/26/2023 Time: 7:17 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 WOODLAWN HOSPITAL (15-1313) 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	Alan Fisher		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	Alan Fisher			2
3	Signatory Title	CEO			3
4	Date	(Dated when report is electronica			4

		Title V	Title XVIII		HIT	Title XIX	
			Part A	Part B			
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	HOSPITAL	0	-507,502	-351,525	0	-1,050	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	-72,588	0		0	5.00
6.00	SWING BED - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		10,884		0	10.00
10.01	RURAL HEALTH CLINIC II	0		-33,257		0	10.01
10.02	RURAL HEALTH CLINIC III	0		19,433		0	10.02
10.03	RURAL HEALTH CLINIC IV	0		-21,790		0	10.03
10.04	RURAL HEALTH CLINIC V	0		-26,347		0	10.04
10.05	RURAL HEALTH CLINIC VI	0		-21,087		0	10.05
200.00	TOTAL	0	-580,090	-423,689	0	-1,050	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: 15-1313 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-2 Part I | Date/Time Prepared: 5/26/2023 7:17 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1400 EAST 9TH STREET	PO Box:			1.00
2.00	City: ROCHESTER	State: IN	Zip Code: 46975-	County: FULTON	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	WOODLAWN HOSPITAL	151313	99915	1	01/01/1966	N	O	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	WOODLAWN HOSPITAL SWINGBED	15Z313	99915		10/23/2001	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC	SHAFER MEDICAL CENTER	158551	99915		04/13/2020	N	O	O	15.00
15.01	Hospital-Based Health Clinic - RHC II	WOODLAWN MEDICAL PROFESSIONALS	158552	99915		04/13/2020	N	O	O	15.01
15.02	Hospital-Based Health Clinic - RHC III	FULTON COUNTY MEDICAL CENTER - MAIN	158550	99915		04/13/2020	N	O	O	15.02
15.03	Hospital-Based Health Clinic - RHC IV	FULTON COUNTY MEDICAL CENTER - DUNN	158549	99915		04/13/2020	N	O	O	15.03
15.04	Hospital-Based Health Clinic - RHC V	AKRON MEDICAL CLINIC	158547	99915		04/13/2020	N	O	O	15.04
15.05	Hospital-Based Health Clinic - RHC VI	ARGOS MEDICAL CLINIC	158548	99915		04/13/2020	N	O	O	15.05
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)	8		21.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1313 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-2 Part I | Date/Time Prepared: 5/26/2023 7:17 pm

		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.	3	N		23.00

		1.00 In-State Medicaid paid days	2.00 In-State Medicaid eligible unpaid days	3.00 Out-of State Medicaid paid days	4.00 Out-of State Medicaid eligible unpaid	5.00 Medicaid HMO days	6.00 Other Medicaid days	
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

		1.00 Urban/Rural S	2.00 Date of Geogr	
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

		1.00 Beginning:	2.00 Ending:	
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

		1.00 Y/N	2.00 Y/N	
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

		1.00 V	2.00 XVIII	3.00 XIX	
	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: 15-1313 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-2 Part I Date/Time Prepared: 5/26/2023 7:17 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.	N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1313	Period: From 01/01/2022 To 12/31/2022	Worksheet S-2 Part I Date/Time Prepared: 5/26/2023 7:17 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: 15-1313 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-2 Part I | Date/Time Prepared: 5/26/2023 7:17 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: 15-1313 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-2 Part I Date/Time Prepared: 5/26/2023 7:17 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	Y	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.06
	Rural Providers			
105.00	Does this hospital qualify as a CAH?	Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N		107.00
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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1313 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-2 Part I Date/Time Prepared: 5/26/2023 7:17 pm

				1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration)for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.			N	110.00
			1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.		N		111.00
		1.00	2.00	3.00	
112.00	Did this hospital participate in the Pennsylvania Rural Health Model (PARHM) demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N			112.00
113.00	Did this hospital participate in the Community Health Access and Rural Transformation (CHART) model for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no.				113.00
	Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.00
		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	282,845	0	0	118.01
			1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.		N		118.02
119.00	DO NOT USE THIS LINE				119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.		N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.		Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.		N		122.00
123.00	Did the facility and/or its subproviders (if applicable) purchase professional services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, and/or management/consulting services, from an unrelated organization? In column 1, enter "Y" for yes or "N" for no. If column 1 is "Y", were the majority of the expenses, i.e., greater than 50% of total professional services expenses, for services purchased from unrelated organizations located in a CBSA outside of the main hospital CBSA? In column 2, enter "Y" for yes or "N" for no.				123.00
	Certified Transplant Center Information				
125.00	Does this facility operate a Medicare-certified transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.		N		125.00
126.00	If this is a Medicare-certified kidney transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.				126.00
127.00	If this is a Medicare-certified heart transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.				127.00
128.00	If this is a Medicare-certified liver transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.				128.00

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		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)	N		140.00

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

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

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

		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: 15-1313	Period: From 01/01/2022 To 12/31/2022	Worksheet S-2 Part I Date/Time Prepared: 5/26/2023 7:17 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: 15-1313 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-2 Part II | Date/Time Prepared: 5/26/2023 7:17 pm

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

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

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

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

		Y/N	
		1.00	
	Bad Debts		
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N	13.00
14.00	If line 12 is yes, were patient deductibles and/or coinsurance amounts waived? If yes, see instructions.	N	14.00
	Bed Complement		
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	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)	Y	03/22/2023	Y	03/22/2023	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1313 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-2 Part II Date/Time Prepared: 5/26/2023 7:17 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.				Y	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.					37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.					38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.					39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.					40.00
		1.00		2.00		
	Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	KYLE		SMITH		41.00
42.00	Enter the employer/company name of the cost report preparer.	BLUE & CO. LLC				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-713-7957		KCSMITH@BLUEANDCO.COM		43.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1313 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-3 Part I Date/Time Prepared: 5/26/2023 7:17 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	21	7,665	49,608.00	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)		21	7,665	49,608.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	4	1,460	3,336.00	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	52,944.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	88.00				0	26.00
26.01	RURAL HEALTH CLINIC II	88.01				0	26.01
26.02	RURAL HEALTH CLINIC III	88.02				0	26.02
26.03	RURAL HEALTH CLINIC IV	88.03				0	26.03
26.04	RURAL HEALTH CLINIC V	88.04				0	26.04
26.05	RURAL HEALTH CLINIC VI	88.05				0	26.05
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: 15-1313 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-3 Part I | Date/Time Prepared: 5/26/2023 7:17 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)	766	60	2,067			1.00
2.00	HMO and other (see instructions)	346	239				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	205	0	205			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	113			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	971	60	2,385			7.00
8.00	INTENSIVE CARE UNIT	58	0	139			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	371			13.00
14.00	Total (see instructions)	1,029	60	2,895	0.00	237.65	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	1,581	910	6,044	0.00	4.26	26.00
26.01	RURAL HEALTH CLINIC II	514	8,087	18,819	0.00	21.76	26.01
26.02	RURAL HEALTH CLINIC III	2,174	3,911	12,890	0.00	14.17	26.02
26.03	RURAL HEALTH CLINIC IV	651	1,125	3,528	0.00	0.84	26.03
26.04	RURAL HEALTH CLINIC V	771	1,081	5,004	0.00	5.85	26.04
26.05	RURAL HEALTH CLINIC VI	2,318	4,777	17,680	0.00	12.09	26.05
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	296.62	27.00
28.00	Observation Bed Days		142	1,201			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	30	123			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: 15-1313 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-3 Part I | Date/Time Prepared: 5/26/2023 7:17 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	201	16	606	1.00
2.00	HMO and other (see instructions)			70	80		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	201	16	606	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0.00					26.00
26.01	RURAL HEALTH CLINIC II	0.00					26.01
26.02	RURAL HEALTH CLINIC III	0.00					26.02
26.03	RURAL HEALTH CLINIC IV	0.00					26.03
26.04	RURAL HEALTH CLINIC V	0.00					26.04
26.05	RURAL HEALTH CLINIC VI	0.00					26.05
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: 15-1313 | Component CCN: 15-8551 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-8 | Date/Time Prepared: 5/26/2023 7:17 pm

RHC I | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			1430 E 9TH STREET		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	ROCHESTER		IN	46975	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

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

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

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

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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-1313 | Component CCN: 15-8551 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-8 | Date/Time Prepared: 5/26/2023 7:17 pm

RHC I | Cost

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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-1313 | Component CCN: 15-8552 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-8 | Date/Time Prepared: 5/26/2023 7:17 pm

RHC II | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			1400 E 9TH STREET		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	ROCHESTER		IN	46975	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

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

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

		Provider name	CCN	
		1.00	2.00	
14.00	RHC/FQHC name, CCN			14.00

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

			County				
			4.00				
2.00	City, State, ZIP Code, County		FULTON				2.00
		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC	17:00	08:00	17:00	08:00	17:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 15-1313
Component CCN: 15-8552

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

Worksheet S-8

Date/Time Prepared:
5/26/2023 7:17 pm

RHC II

Cost

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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-1313 | Component CCN: 15-8550 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-8 | Date/Time Prepared: 5/26/2023 7:17 pm

RHC III | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			700 MAIN STREET		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	ROCHESTER		IN	46975	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

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

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

		Provider name	CCN	
		1.00	2.00	
14.00	RHC/FQHC name, CCN			14.00

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

			County				
			4.00				
2.00	City, State, ZIP Code, County		FULTON				2.00
		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC	17:00	08:00	17:00	08:00	17:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-1313 | Component CCN: 15-8550 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-8 | Date/Time Prepared: 5/26/2023 7:17 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	17:00				11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-1313 | Component CCN: 15-8549 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-8 | Date/Time Prepared: 5/26/2023 7:17 pm

RHC IV | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			100 EAST DUNN STREET		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	FULTON		IN	46931	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

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

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

		Provider name	CCN	
		1.00	2.00	
14.00	RHC/FQHC name, CCN			14.00

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

			County				
			4.00				
2.00	City, State, ZIP Code, County		FULTON				2.00
		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC	17:00	08:00	17:00	08:00	17:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 15-1313
Component CCN: 15-8549

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

Worksheet S-8

Date/Time Prepared:
5/26/2023 7:17 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	08:00	17:00				11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-1313 | Component CCN: 15-8547 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-8 | Date/Time Prepared: 5/26/2023 7:17 pm

RHC V | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			105 SR 14 N		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	AKRON		IN	46910	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

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

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

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

			County				
			4.00				
2.00	City, State, ZIP Code, County		FULTON				2.00

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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-1313 | Component CCN: 15-8547 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-8 | Date/Time Prepared: 5/26/2023 7:17 pm

RHC V | 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	17:00				11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-1313 | Component CCN: 15-8548 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-8 | Date/Time Prepared: 5/26/2023 7:17 pm

RHC VI | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			530 N MICHIGAN STREET		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	ARGOS		IN	46501	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

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

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

		Provider name	CCN	
		1.00	2.00	
14.00	RHC/FQHC name, CCN			14.00

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

			County				
			4.00				
2.00	City, State, ZIP Code, County		MARSHALL				2.00
		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC	17:00	08:00	17:00	08:00	17:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-1313 | Component CCN: 15-8548 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-8 | Date/Time Prepared: 5/26/2023 7:17 pm

RHC VI | 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	17:00				11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 15-1313	Period: From 01/01/2022 To 12/31/2022	Worksheet S-10 Date/Time Prepared: 5/26/2023 7:17 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)	0.338570	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	526,807	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	26,141,245	6.00
7.00	Medicaid cost (line 1 times line 6)	8,850,641	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)	8,323,834	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)	8,323,834	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)	861,361	0	861,361	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	291,631	0	291,631	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)	291,631	0	291,631	23.00

		1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	4,475,302	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	224,131	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	344,816	27.01
28.00	Non-Medicare bad debt expense (see instructions)	4,130,486	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	1,519,144	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,810,775	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	10,134,609	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1313 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A | Date/Time Prepared: 5/26/2023 7:17 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		2,494,044	2,494,044	-133,980	2,360,064	1.00
1.02	00102	AKRON BUILDING		36,324	36,324	0	36,324	1.02
1.03	00103	ARGOS BUILDING		81,690	81,690	0	81,690	1.03
1.04	00101	CLAYS BUILDING		31,098	31,098	133,980	165,078	1.04
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	2,883,737	2,883,737	0	2,883,737	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,829,398	7,040,571	10,869,969	234,514	11,104,483	5.00
7.00	00700	OPERATION OF PLANT	395,747	1,173,623	1,569,370	1,191,161	2,760,531	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	36,448	117,449	153,897	0	153,897	8.00
9.00	00900	HOUSEKEEPING	304,873	191,445	496,318	-527	495,791	9.00
10.00	01000	DIETARY	455,752	364,761	820,513	-558,613	261,900	10.00
11.00	01100	CAFETERIA	0	0	0	545,438	545,438	11.00
13.00	01300	NURSING ADMINISTRATION	195,165	103,428	298,593	368,887	667,480	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	408,975	3,522,556	3,931,531	-38,516	3,893,015	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	327,543	1,123,963	1,451,506	-61,310	1,390,196	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,308,312	1,155,422	3,463,734	-1,175,701	2,288,033	30.00
31.00	03100	INTENSIVE CARE UNIT	413,823	132,529	546,352	-4,386	541,966	31.00
43.00	04300	NURSERY	0	0	0	613,877	613,877	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	782,327	2,021,910	2,804,237	-276,065	2,528,172	50.00
51.00	05100	RECOVERY ROOM	415,906	203,430	619,336	0	619,336	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	172,321	172,321	52.00
53.00	05300	ANESTHESIOLOGY	0	818,594	818,594	0	818,594	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,659,736	1,435,296	3,095,032	-130,942	2,964,090	54.00
60.00	06000	LABORATORY	999,022	2,170,793	3,169,815	-102,009	3,067,806	60.00
65.00	06500	RESPIRATORY THERAPY	1,045,710	449,855	1,495,565	-9,310	1,486,255	65.00
66.00	06600	PHYSICAL THERAPY	581,683	196,192	777,875	-1,112	776,763	66.00
67.00	06700	OCCUPATIONAL THERAPY	200,910	58,948	259,858	0	259,858	67.00
68.00	06800	SPEECH PATHOLOGY	44,083	11,532	55,615	0	55,615	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	621,026	621,026	0	621,026	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	734,823	770,821	1,505,644	15,108	1,520,752	88.00
88.01	08801	RURAL HEALTH CLINIC II	3,268,480	1,525,686	4,794,166	-608,110	4,186,056	88.01
88.02	08802	RURAL HEALTH CLINIC III	1,468,700	896,923	2,365,623	-1,762	2,363,861	88.02
88.03	08803	RURAL HEALTH CLINIC IV	325,760	118,117	443,877	49,549	493,426	88.03
88.04	08804	RURAL HEALTH CLINIC V	590,736	222,041	812,777	-11,868	800,909	88.04
88.05	08805	RURAL HEALTH CLINIC VI	1,125,877	1,207,328	2,333,205	-19,011	2,314,194	88.05
91.00	09100	EMERGENCY	1,751,257	2,554,777	4,306,034	-11,067	4,294,967	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	WOODLAWN MEDICAL PROFESSIONALS	632,708	519,854	1,152,562	-3,557	1,149,005	93.00
93.01	04951	SHAFER MEDICAL CENTER	1,689,881	557,666	2,247,547	-68,701	2,178,846	93.01
93.02	04040	INTERNAL MEDICINE	746,581	65,356	811,937	0	811,937	93.02
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	26,740,216	36,878,785	63,619,001	108,288	63,727,289	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	FCMC	0	0	0	0	0	192.01
192.02	19202	ARGOS MEDICAL CENTER	0	0	0	0	0	192.02
192.03	19203	AKRON MEDICAL CENTER	0	0	0	0	0	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	ADVERTISING	58,116	226,627	284,743	-108,288	176,455	194.00
194.01	07951	LTC/WELLNESS	28,779	8,526	37,305	0	37,305	194.01
200.00		TOTAL (SUM OF LINES 118 through 199)	26,827,111	37,113,938	63,941,049	0	63,941,049	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1313 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A | Date/Time Prepared: 5/26/2023 7:17 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	-28,588	2,331,476		1.00
1.02	00102	AKRON BUILDING	0	36,324		1.02
1.03	00103	ARGOS BUILDING	0	81,690		1.03
1.04	00101	CLAYS BUILDING	0	165,078		1.04
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	2,883,737		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-3,038,626	8,065,857		5.00
7.00	00700	OPERATION OF PLANT	0	2,760,531		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	153,897		8.00
9.00	00900	HOUSEKEEPING	0	495,791		9.00
10.00	01000	DIETARY	-12,827	249,073		10.00
11.00	01100	CAFETERIA	-114,259	431,179		11.00
13.00	01300	NURSING ADMINISTRATION	0	667,480		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0		14.00
15.00	01500	PHARMACY	-3,439	3,889,576		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-10,683	1,379,513		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	2,288,033		30.00
31.00	03100	INTENSIVE CARE UNIT	0	541,966		31.00
43.00	04300	NURSERY	0	613,877		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	2,528,172		50.00
51.00	05100	RECOVERY ROOM	0	619,336		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	172,321		52.00
53.00	05300	ANESTHESIOLOGY	-770,000	48,594		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-194,265	2,769,825		54.00
60.00	06000	LABORATORY	0	3,067,806		60.00
65.00	06500	RESPIRATORY THERAPY	-187,325	1,298,930		65.00
66.00	06600	PHYSICAL THERAPY	-1,934	774,829		66.00
67.00	06700	OCCUPATIONAL THERAPY	-41,833	218,025		67.00
68.00	06800	SPEECH PATHOLOGY	0	55,615		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	621,026		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	-236,353	1,284,399		88.00
88.01	08801	RURAL HEALTH CLINIC II	-222,217	3,963,839		88.01
88.02	08802	RURAL HEALTH CLINIC III	-84,771	2,279,090		88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	493,426		88.03
88.04	08804	RURAL HEALTH CLINIC V	-21,185	779,724		88.04
88.05	08805	RURAL HEALTH CLINIC VI	-31,408	2,282,786		88.05
91.00	09100	EMERGENCY	-1,468,875	2,826,092		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
93.00	04950	WOODLAWN MEDICAL PROFESSIONALS	-950,500	198,505		93.00
93.01	04951	SHAFER MEDICAL CENTER	-1,600,193	578,653		93.01
93.02	04040	INTERNAL MEDICINE	-711,736	100,201		93.02
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-9,731,017	53,996,272		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0		192.00
192.01	19201	FCMC	0	0		192.01
192.02	19202	ARGOS MEDICAL CENTER	0	0		192.02
192.03	19203	AKRON MEDICAL CENTER	0	0		192.03
193.00	19300	NONPAID WORKERS	0	0		193.00
194.00	07950	ADVERTISING	0	176,455		194.00
194.01	07951	LTC/WELLNESS	0	37,305		194.01
200.00		TOTAL (SUM OF LINES 118 through 199)	-9,731,017	54,210,032		200.00

RECLASSIFICATIONS | Provider CCN: 15-1313 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-6 | Date/Time Prepared: 5/26/2023 7:17 pm

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - CAFETERIA RECLASS				
1.00	CAFETERIA	11.00	307,906	237,532	1.00
	0		307,906	237,532	
	B - ADVERTISING RECLASS				
1.00	ADMINISTRATIVE & GENERAL	5.00	22,102	86,186	1.00
	0		22,102	86,186	
	C - DEPRECIATION RECLASS				
1.00	CLAYS BUILDING	1.04	0	133,980	1.00
	0		0	133,980	
	D - NURSERY RECLASS				
1.00	NURSERY	43.00	407,595	206,282	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	114,416	57,905	2.00
	0		522,011	264,187	
	E - NURSING SUPERVISOR RECLASS				
1.00	NURSING ADMINISTRATION	13.00	371,782	0	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
	0		371,782	0	
	F - MAINTENANCE RECLASS				
1.00	OPERATION OF PLANT	7.00	0	1,191,161	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
	0		0	1,191,161	
	G - RENT RECLASS				
1.00	RURAL HEALTH CLINIC IV	88.03	0	40,086	1.00
	0		0	40,086	
	H - RHC OVERHEAD RECLASS				
1.00	ADMINISTRATIVE & GENERAL	5.00	0	564,198	1.00
2.00	RURAL HEALTH CLINIC	88.00	5,863	0	2.00
3.00	RURAL HEALTH CLINIC III	88.02	12,470	0	3.00
4.00	RURAL HEALTH CLINIC IV	88.03	3,425	0	4.00
5.00	RURAL HEALTH CLINIC V	88.04	4,907	0	5.00
6.00	RURAL HEALTH CLINIC VI	88.05	17,247	0	6.00
	0		43,912	564,198	
	J - CLINIC SUPERVISOR				
1.00	RURAL HEALTH CLINIC	88.00	9,245	0	1.00
2.00	RURAL HEALTH CLINIC III	88.02	25,854	0	2.00
3.00	RURAL HEALTH CLINIC IV	88.03	6,038	0	3.00
	0		41,137	0	
500.00	Grand Total: Increases		1,308,850	2,517,330	500.00

RECLASSIFICATIONS | Provider CCN: 15-1313 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-6 | Date/Time Prepared: 5/26/2023 7:17 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - CAFETERIA RECLASS						
1.00	DIETARY	10.00	307,906	237,532	0		1.00
	0		307,906	237,532			
	B - ADVERTISING RECLASS						
1.00	ADVERTISING	194.00	22,102	86,186	0		1.00
	0		22,102	86,186			
	C - DEPRECIATION RECLASS						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	133,980	9		1.00
	0		0	133,980			
	D - NURSERY RECLASS						
1.00	ADULTS & PEDIATRICS	30.00	522,011	264,187	0		1.00
2.00		0.00	0	0	0		2.00
	0		522,011	264,187			
	E - NURSING SUPERVISOR RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	3,303	0	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	364,023	0	0		2.00
3.00	RADIOLOGY-DIAGNOSTIC	54.00	4,456	0	0		3.00
	0		371,782	0			
	F - MAINTENANCE RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00		434,669	0		1.00
2.00	HOUSEKEEPING	9.00		527	0		2.00
3.00	DIETARY	10.00		13,175	0		3.00
4.00	NURSING ADMINISTRATION	13.00		2,895	0		4.00
5.00	PHARMACY	15.00		38,516	0		5.00
6.00	MEDICAL RECORDS & LIBRARY	16.00		61,310	0		6.00
7.00	ADULTS & PEDIATRICS	30.00		25,480	0		7.00
8.00	INTENSIVE CARE UNIT	31.00		4,386	0		8.00
9.00	OPERATING ROOM	50.00		276,065	0		9.00
10.00	RADIOLOGY-DIAGNOSTIC	54.00		126,486	0		10.00
11.00	LABORATORY	60.00		102,009	0		11.00
12.00	RESPIRATORY THERAPY	65.00		9,310	0		12.00
13.00	PHYSICAL THERAPY	66.00		1,112	0		13.00
14.00	RURAL HEALTH CLINIC V	88.04		16,775	0		14.00
15.00	RURAL HEALTH CLINIC VI	88.05		36,258	0		15.00
16.00	EMERGENCY	91.00		11,067	0		16.00
17.00	WOODLAWN MEDICAL PROFESSIONALS	93.00		3,557	0		17.00
18.00	SHAFER MEDICAL CENTER	93.01		27,564	0		18.00
	0		0	1,191,161			
	G - RENT RECLASS						
1.00	RURAL HEALTH CLINIC III	88.02	0	40,086	0		1.00
	0		0	40,086			
	H - RHC OVERHEAD RECLASS						
1.00	RURAL HEALTH CLINIC II	88.01	43,912	564,198	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
	0		43,912	564,198			
	J - CLINIC SUPERVISOR						
1.00	SHAFER MEDICAL CENTER	93.01	41,137	0	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	0		41,137	0			
500.00	Grand Total: Decreases		1,308,850	2,517,330			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1313 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-7 Part I | Date/Time Prepared: 5/26/2023 7:17 pm

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	596,216	0	0	0	0	1.00
2.00	Land Improvements	513,782	0	0	0	0	2.00
3.00	Buildings and Fixtures	27,528,763	2,106,377	0	2,106,377	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	11,394,525	4,915,445	0	4,915,445	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	40,033,286	7,021,822	0	7,021,822	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	40,033,286	7,021,822	0	7,021,822	0	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	596,216	0	1.00
2.00	Land Improvements	513,782	0	2.00
3.00	Buildings and Fixtures	29,635,140	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	16,309,970	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	47,055,108	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	47,055,108	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1313 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-7 Part II | Date/Time Prepared: 5/26/2023 7:17 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	1,454,501	0	419,744	572,422	0	1.00
1.02	AKRON BUILDING	14,473	0	0	0	0	1.02
1.03	ARGOS BUILDING	26,691	0	0	22,495	0	1.03
1.04	CLAYS BUILDING	0	0	0	0	0	1.04
3.00	Total (sum of lines 1-2)	1,495,665	0	419,744	594,917	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL		
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	CAP REL COSTS-BLDG & FIXT	47,377	2,494,044	1.00
1.02	AKRON BUILDING	21,851	36,324	1.02
1.03	ARGOS BUILDING	32,504	81,690	1.03
1.04	CLAYS BUILDING	31,098	31,098	1.04
3.00	Total (sum of lines 1-2)	132,830	2,643,156	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1313 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-7 Part III Date/Time Prepared: 5/26/2023 7:17 pm

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	36,516,371	0	36,516,371	0.776034	0	1.00
1.02	AKRON BUILDING	1,174,214	0	1,174,214	0.024954	0	1.02
1.03	ARGOS BUILDING	2,516,172	0	2,516,172	0.053473	0	1.03
1.04	CLAYS BUILDING	6,848,350	0	6,848,350	0.145539	0	1.04
3.00	Total (sum of lines 1-2)	47,055,107	0	47,055,107	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1,319,880	0	1.00
1.02	AKRON BUILDING	0	0	0	14,473	0	1.02
1.03	ARGOS BUILDING	0	0	0	26,691	0	1.03
1.04	CLAYS BUILDING	0	0	0	133,980	0	1.04
3.00	Total (sum of lines 1-2)	0	0	0	1,495,024	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	391,797	572,422	0	47,377	2,331,476	1.00
1.02	AKRON BUILDING	0	0	0	21,851	36,324	1.02
1.03	ARGOS BUILDING	0	22,495	0	32,504	81,690	1.03
1.04	CLAYS BUILDING	0	0	0	31,098	165,078	1.04
3.00	Total (sum of lines 1-2)	391,797	594,917	0	132,830	2,614,568	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1313 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-8 | Date/Time Prepared: 5/26/2023 7:17 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-27,947	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
1.02	Investment income - AKRON BUILDING (chapter 2)		0	AKRON BUILDING	1.02	0	1.02
1.03	Investment income - ARGOS BUILDING (chapter 2)		0	ARGOS BUILDING	1.03	0	1.03
1.04	Investment income - CLAYS BUILDING (chapter 2)		0	CLAYS BUILDING	1.04	0	1.04
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	*** Cost Center Deleted ***	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-5,713,609			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-114,250	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-10,683	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	-9	CAFETERIA	11.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
26.02	Depreciation - AKRON BUILDING		0	AKRON BUILDING	1.02	0	26.02
26.03	Depreciation - ARGOS BUILDING		0	ARGOS BUILDING	1.03	0	26.03
26.04	Depreciation - CLAYS BUILDING		0	CLAYS BUILDING	1.04	0	26.04
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	*** Cost Center Deleted ***	2.00	0	27.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1313 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-8 | Date/Time Prepared: 5/26/2023 7:17 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	
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	B	-641	CAP REL COSTS-BLDG & FIXT	1.00	9	32.00
33.00	PHYSICIAN RECRUITMENT	A	3,050	ADMINISTRATIVE & GENERAL	5.00	0	33.00
34.00	PHYSICIAN RECRUITMENT	A	-68,442	ADMINISTRATIVE & GENERAL	5.00	0	34.00
34.01	HAF EXPENSE	A	-2,802,386	ADMINISTRATIVE & GENERAL	5.00	0	34.01
35.00	ADMIN OTHER REVENUE	B	-2,698	ADMINISTRATIVE & GENERAL	5.00	0	35.00
36.00	HOME MEAL PROGRAM	B	-12,827	DIETARY	10.00	0	36.00
37.00	DRUG SALES	B	-3,439	PHARMACY	15.00	0	37.00
38.00	PT - OTHER REVENUE	B	-1,934	PHYSICAL THERAPY	66.00	0	38.00
39.00	OCC THER OTH REV	B	-41,833	OCCUPATIONAL THERAPY	67.00	0	39.00
40.00	MISC REV -OTH REV	B	-55,593	ADMINISTRATIVE & GENERAL	5.00	0	40.00
41.00	STAFF RENTAL AGREEMENTS	B	-169,285	RESPIRATORY THERAPY	65.00	0	41.00
42.00	IHA & AHA LOBBYING	A	-1,783	ADMINISTRATIVE & GENERAL	5.00	0	42.00
43.00	PART B BILLING OFFSET	A	-17,683	ADMINISTRATIVE & GENERAL	5.00	0	43.00
44.00	LTC EXPENSES	A	-93,091	ADMINISTRATIVE & GENERAL	5.00	0	44.00
45.00	RHC OFFSETS	A	-236,353	RURAL HEALTH CLINIC	88.00	0	45.00
45.01	RHC OFFSETS	A	-222,217	RURAL HEALTH CLINIC II	88.01	0	45.01
45.02	RHC OFFSETS	A	-84,771	RURAL HEALTH CLINIC III	88.02	0	45.02
45.03	RHC OFFSETS	A	-21,185	RURAL HEALTH CLINIC V	88.04	0	45.03
45.04	RHC OFFSETS	A	-31,408	RURAL HEALTH CLINIC VI	88.05	0	45.04
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-9,731,017				50.00

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-1313 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-8-2 | Date/Time Prepared: 5/26/2023 7:17 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	53.00	ANESTHESIOLOGY	782,000	770,000	12,000	0	0	1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	194,265	194,265	0	0	0	2.00
3.00	65.00	RESPIRATORY THERAPY	26,690	18,040	8,650	0	0	3.00
4.00	91.00	EMERGENCY	2,426,318	1,468,875	957,443	0	0	4.00
5.00	93.00	WOODLAWN MEDICAL PROFESSIONALS	950,500	950,500	0	0	0	5.00
6.00	93.01	SHAFER MEDICAL CENTER	1,600,193	1,600,193	0	0	0	6.00
7.00	93.02	INTERNAL MEDICINE	711,736	711,736	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			6,691,702	5,713,609	978,093		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	53.00	ANESTHESIOLOGY	0	0	0	0	0	1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	2.00
3.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	3.00
4.00	91.00	EMERGENCY	0	0	0	0	0	4.00
5.00	93.00	WOODLAWN MEDICAL PROFESSIONALS	0	0	0	0	0	5.00
6.00	93.01	SHAFER MEDICAL CENTER	0	0	0	0	0	6.00
7.00	93.02	INTERNAL MEDICINE	0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	53.00	ANESTHESIOLOGY	0	0	0	770,000		1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	194,265		2.00
3.00	65.00	RESPIRATORY THERAPY	0	0	0	18,040		3.00
4.00	91.00	EMERGENCY	0	0	0	1,468,875		4.00
5.00	93.00	WOODLAWN MEDICAL PROFESSIONALS	0	0	0	950,500		5.00
6.00	93.01	SHAFER MEDICAL CENTER	0	0	0	1,600,193		6.00
7.00	93.02	INTERNAL MEDICINE	0	0	0	711,736		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	5,713,609		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1313 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part I | Date/Time Prepared: 5/26/2023 7:17 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	AKRON BUILDING	ARGOS BUILDING	CLAYS BUILDING	
			0	1.00	1.02	1.03	1.04	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	2,331,476	2,331,476				1.00
1.02	00102	AKRON BUILDING	36,324	0	36,324			1.02
1.03	00103	ARGOS BUILDING	81,690	0	0	81,690		1.03
1.04	00101	CLAYS BUILDING	165,078	0	0	0	165,078	1.04
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,883,737	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	8,065,857	250,294	4,151	6,535	129	5.00
7.00	00700	OPERATION OF PLANT	2,760,531	226,882	2,491	7,450	37,659	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	153,897	6,876	0	0	0	8.00
9.00	00900	HOUSEKEEPING	495,791	25,983	0	0	348	9.00
10.00	01000	DIETARY	249,073	82,468	0	0	0	10.00
11.00	01100	CAFETERIA	431,179	31,787	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	667,480	54,686	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	3,889,576	29,688	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,379,513	28,275	0	0	34,360	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,288,033	323,357	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	541,966	44,083	0	0	0	31.00
43.00	04300	NURSERY	613,877	4,006	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,528,172	176,545	0	0	0	50.00
51.00	05100	RECOVERY ROOM	619,336	105,751	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	172,321	17,008	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	48,594	2,935	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,769,825	255,799	0	0	0	54.00
60.00	06000	LABORATORY	3,067,806	56,185	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,298,930	89,086	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	774,829	67,495	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	218,025	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	55,615	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	621,026	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	1,284,399	0	0	0	45,559	88.00
88.01	08801	RURAL HEALTH CLINIC II	3,963,839	164,442	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	2,279,090	0	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	493,426	0	0	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	779,724	0	29,682	0	0	88.04
88.05	08805	RURAL HEALTH CLINIC VI	2,282,786	0	0	67,705	0	88.05
91.00	09100	EMERGENCY	2,826,092	134,047	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	WOODLAWN MEDICAL PROFESSIONALS	198,505	122,588	0	0	0	93.00
93.01	04951	SHAFER MEDICAL CENTER	578,653	0	0	0	47,023	93.01
93.02	04040	INTERNAL MEDICINE	100,201	11,610	0	0	0	93.02
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	53,996,272	2,311,876	36,324	81,690	165,078	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	12,531	0	0	0	192.00
192.01	19201	FCMC	0	0	0	0	0	192.01
192.02	19202	ARGOS MEDICAL CENTER	0	0	0	0	0	192.02
192.03	19203	AKRON MEDICAL CENTER	0	0	0	0	0	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	ADVERTISING	176,455	7,069	0	0	0	194.00
194.01	07951	LTC/WELLNESS	37,305	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	54,210,032	2,331,476	36,324	81,690	165,078	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1313 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part I | Date/Time Prepared: 5/26/2023 7:17 pm

		Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			4.00	4A	5.00	7.00	8.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.02	00102	AKRON BUILDING						1.02
1.03	00103	ARGOS BUILDING						1.03
1.04	00101	CLAYS BUILDING						1.04
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,883,737					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	413,663	8,740,629	8,740,629			5.00
7.00	00700	OPERATION OF PLANT	42,540	3,077,553	591,601	3,669,154		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,918	164,691	31,659	10,662	207,012	8.00
9.00	00900	HOUSEKEEPING	32,772	554,894	106,668	41,717	37,488	9.00
10.00	01000	DIETARY	15,892	347,433	66,787	127,874	4,067	10.00
11.00	01100	CAFETERIA	33,098	496,064	95,359	49,290	0	11.00
13.00	01300	NURSING ADMINISTRATION	60,943	783,109	150,538	84,795	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	43,962	3,963,226	761,855	46,035	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	35,209	1,477,357	283,994	184,969	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	152,885	2,764,275	531,379	501,400	35,074	30.00
31.00	03100	INTENSIVE CARE UNIT	44,483	630,532	121,208	68,354	0	31.00
43.00	04300	NURSERY	43,814	661,697	127,199	6,211	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	84,095	2,788,812	536,096	273,750	9,023	50.00
51.00	05100	RECOVERY ROOM	44,707	769,794	147,978	163,978	8,641	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	12,299	201,628	38,759	26,372	0	52.00
53.00	05300	ANESTHESIOLOGY	0	51,529	9,905	4,550	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	177,931	3,203,555	615,823	396,642	43,969	54.00
60.00	06000	LABORATORY	107,388	3,231,379	621,171	87,120	0	60.00
65.00	06500	RESPIRATORY THERAPY	112,407	1,500,423	288,428	138,137	4,829	65.00
66.00	06600	PHYSICAL THERAPY	62,527	904,851	173,940	104,657	5,846	66.00
67.00	06700	OCCUPATIONAL THERAPY	21,596	239,621	46,063	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	4,739	60,354	11,602	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	621,026	119,380	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	80,612	1,410,570	271,155	187,128	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	346,618	4,474,899	860,215	254,984	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	161,995	2,441,085	469,252	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	36,034	529,460	101,779	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	64,027	873,433	167,901	94,992	0	88.04
88.05	08805	RURAL HEALTH CLINIC VI	122,878	2,473,369	475,458	206,458	0	88.05
91.00	09100	EMERGENCY	188,248	3,148,387	605,218	207,853	58,075	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0				92.00
93.00	04950	WOODLAWN MEDICAL PROFESSIONALS	68,012	389,105	74,798	190,084	0	93.00
93.01	04951	SHAFER MEDICAL CENTER	177,228	802,904	154,343	193,140	0	93.01
93.02	04040	INTERNAL MEDICINE	80,252	192,063	36,920	18,002	0	93.02
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,876,772	53,969,707	8,694,431	3,669,154	207,012	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	12,531	2,409	0	0	192.00
192.01	19201	FCMC	0	0	0	0	0	192.01
192.02	19202	ARGOS MEDICAL CENTER	0	0	0	0	0	192.02
192.03	19203	AKRON MEDICAL CENTER	0	0	0	0	0	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	ADVERTISING	3,871	187,395	36,023	0	0	194.00
194.01	07951	LTC/WELLNESS	3,094	40,399	7,766	0	0	194.01
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)	2,883,737	54,210,032	8,740,629	3,669,154	207,012	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1313 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part I | Date/Time Prepared: 5/26/2023 7:17 pm

		Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			9.00	10.00	11.00	13.00	14.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.02	00102	AKRON BUILDING						1.02
1.03	00103	ARGOS BUILDING						1.03
1.04	00101	CLAYS BUILDING						1.04
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	740,767					9.00
10.00	01000	DIETARY	700	546,861				10.00
11.00	01100	CAFETERIA	14,177	0	654,890			11.00
13.00	01300	NURSING ADMINISTRATION	550	0	22,164	1,041,156		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	4,551	0	17,130	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,075	0	22,632	81,007	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	173,397	527,107	77,028	696,688	0	30.00
31.00	03100	INTENSIVE CARE UNIT	17,752	19,754	14,048	101,759	0	31.00
43.00	04300	NURSERY	0	0	20,135	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	100,212	0	39,997	0	0	50.00
51.00	05100	RECOVERY ROOM	55,732	0	19,120	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	5,658	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	75,734	0	83,193	0	0	54.00
60.00	06000	LABORATORY	27,878	0	66,492	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	30,829	0	56,541	0	0	65.00
66.00	06600	PHYSICAL THERAPY	19,752	0	27,354	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	8,311	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	1,795	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	29,179	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	54,082	0	84,909	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	0	0	0	0	88.04
88.05	08805	RURAL HEALTH CLINIC VI	0	0	0	0	0	88.05
91.00	09100	EMERGENCY	85,686	0	60,092	161,702	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	WOODLAWN MEDICAL PROFESSIONALS	17,777	0	14,750	0	0	93.00
93.01	04951	SHAFER MEDICAL CENTER	28,904	0	0	0	0	93.01
93.02	04040	INTERNAL MEDICINE	0	0	10,575	0	0	93.02
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	739,967	546,861	651,924	1,041,156	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	800	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	FCMC	0	0	0	0	0	192.01
192.02	19202	ARGOS MEDICAL CENTER	0	0	0	0	0	192.02
192.03	19203	AKRON MEDICAL CENTER	0	0	0	0	0	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	ADVERTISING	0	0	1,834	0	0	194.00
194.01	07951	LTC/WELLNESS	0	0	1,132	0	0	194.01
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)	740,767	546,861	654,890	1,041,156	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1313 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part I | Date/Time Prepared: 5/26/2023 7:17 pm

		Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			15.00	16.00	24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.02	00102	AKRON BUILDING						1.02
1.03	00103	ARGOS BUILDING						1.03
1.04	00101	CLAYS BUILDING						1.04
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	4,792,797					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	2,053,034				16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	97,340	5,403,688	0	5,403,688	30.00
31.00	03100	INTENSIVE CARE UNIT	0	5,280	978,687	0	978,687	31.00
43.00	04300	NURSERY	0	4,146	819,388	0	819,388	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	225,169	3,973,059	0	3,973,059	50.00
51.00	05100	RECOVERY ROOM	0	20,994	1,186,237	0	1,186,237	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	4,321	276,738	0	276,738	52.00
53.00	05300	ANESTHESIOLOGY	0	26,592	92,576	0	92,576	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	452,700	4,871,616	0	4,871,616	54.00
60.00	06000	LABORATORY	0	409,842	4,443,882	0	4,443,882	60.00
65.00	06500	RESPIRATORY THERAPY	0	124,875	2,144,062	0	2,144,062	65.00
66.00	06600	PHYSICAL THERAPY	0	31,360	1,267,760	0	1,267,760	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	10,787	304,782	0	304,782	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,031	74,782	0	74,782	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	18,631	759,037	0	759,037	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,792,797	271,294	5,064,091	0	5,064,091	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	18,609	1,916,641	0	1,916,641	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	67,236	5,796,325	0	5,796,325	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	32,799	2,943,136	0	2,943,136	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	7,661	638,900	0	638,900	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	12,343	1,148,669	0	1,148,669	88.04
88.05	08805	RURAL HEALTH CLINIC VI	0	43,961	3,199,246	0	3,199,246	88.05
91.00	09100	EMERGENCY	0	99,648	4,426,661	0	4,426,661	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
93.00	04950	WOODLAWN MEDICAL PROFESSIONALS	0	13,870	700,384	0	700,384	93.00
93.01	04951	SHAFER MEDICAL CENTER	0	34,594	1,213,885	0	1,213,885	93.01
93.02	04040	INTERNAL MEDICINE	0	17,951	275,511	0	275,511	93.02
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	4,792,797	2,053,034	53,919,743	0	53,919,743	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	800	0	800	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	14,940	0	14,940	192.00
192.01	19201	FCMC	0	0	0	0	0	192.01
192.02	19202	ARGOS MEDICAL CENTER	0	0	0	0	0	192.02
192.03	19203	AKRON MEDICAL CENTER	0	0	0	0	0	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	ADVERTISING	0	0	225,252	0	225,252	194.00
194.01	07951	LTC/WELLNESS	0	0	49,297	0	49,297	194.01
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	4,792,797	2,053,034	54,210,032	0	54,210,032	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1313 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part II | Date/Time Prepared: 5/26/2023 7:17 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	AKRON BUILDING	ARGOS BUILDING	CLAYS BUILDING	
			0	1.00	1.02	1.03	1.04	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.02	00102	AKRON BUILDING						1.02
1.03	00103	ARGOS BUILDING						1.03
1.04	00101	CLAYS BUILDING						1.04
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	250,294	4,151	6,535	129	5.00
7.00	00700	OPERATION OF PLANT	0	226,882	2,491	7,450	37,659	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	6,876	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	25,983	0	0	348	9.00
10.00	01000	DIETARY	0	82,468	0	0	0	10.00
11.00	01100	CAFETERIA	0	31,787	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	54,686	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	29,688	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	28,275	0	0	34,360	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	323,357	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	44,083	0	0	0	31.00
43.00	04300	NURSERY	0	4,006	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	176,545	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	105,751	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	17,008	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	2,935	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	255,799	0	0	0	54.00
60.00	06000	LABORATORY	0	56,185	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	89,086	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	67,495	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 PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	45,559	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	164,442	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	0	29,682	0	0	88.04
88.05	08805	RURAL HEALTH CLINIC VI	0	0	0	67,705	0	88.05
91.00	09100	EMERGENCY	0	134,047	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	WOODLAWN MEDICAL PROFESSIONALS	0	122,588	0	0	0	93.00
93.01	04951	SHAFER MEDICAL CENTER	0	0	0	0	47,023	93.01
93.02	04040	INTERNAL MEDICINE	0	11,610	0	0	0	93.02
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	2,311,876	36,324	81,690	165,078	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	12,531	0	0	0	192.00
192.01	19201	FCMC	0	0	0	0	0	192.01
192.02	19202	ARGOS MEDICAL CENTER	0	0	0	0	0	192.02
192.03	19203	AKRON MEDICAL CENTER	0	0	0	0	0	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	ADVERTISING	0	7,069	0	0	0	194.00
194.01	07951	LTC/WELLNESS	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	2,331,476	36,324	81,690	165,078	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1313 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part II | Date/Time Prepared: 5/26/2023 7:17 pm

		Cost Center Description	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			2A	4.00	5.00	7.00	8.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.02	00102	AKRON BUILDING						1.02
1.03	00103	ARGOS BUILDING						1.03
1.04	00101	CLAYS BUILDING						1.04
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0				4.00
5.00	00500	ADMINISTRATIVE & GENERAL	261,109	0	261,109			5.00
7.00	00700	OPERATION OF PLANT	274,482	0	17,674	292,156		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	6,876	0	946	849	8,671	8.00
9.00	00900	HOUSEKEEPING	26,331	0	3,187	3,322	1,570	9.00
10.00	01000	DIETARY	82,468	0	1,995	10,182	170	10.00
11.00	01100	CAFETERIA	31,787	0	2,849	3,925	0	11.00
13.00	01300	NURSING ADMINISTRATION	54,686	0	4,497	6,752	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	29,688	0	22,761	3,666	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	62,635	0	8,484	14,728	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	323,357	0	15,875	39,923	1,469	30.00
31.00	03100	INTENSIVE CARE UNIT	44,083	0	3,621	5,443	0	31.00
43.00	04300	NURSERY	4,006	0	3,800	495	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	176,545	0	16,016	21,797	378	50.00
51.00	05100	RECOVERY ROOM	105,751	0	4,421	13,057	362	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	17,008	0	1,158	2,100	0	52.00
53.00	05300	ANESTHESIOLOGY	2,935	0	296	362	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	255,799	0	18,398	31,583	1,842	54.00
60.00	06000	LABORATORY	56,185	0	18,558	6,937	0	60.00
65.00	06500	RESPIRATORY THERAPY	89,086	0	8,617	10,999	202	65.00
66.00	06600	PHYSICAL THERAPY	67,495	0	5,197	8,333	245	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	1,376	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	347	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	3,567	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	45,559	0	8,101	14,900	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	164,442	0	25,677	20,303	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	14,019	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	3,041	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	29,682	0	5,016	7,564	0	88.04
88.05	08805	RURAL HEALTH CLINIC VI	67,705	0	14,205	16,439	0	88.05
91.00	09100	EMERGENCY	134,047	0	18,081	16,550	2,433	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0					92.00
93.00	04950	WOODLAWN MEDICAL PROFESSIONALS	122,588	0	2,235	15,135	0	93.00
93.01	04951	SHAFER MEDICAL CENTER	47,023	0	4,611	15,379	0	93.01
93.02	04040	INTERNAL MEDICINE	11,610	0	1,103	1,433	0	93.02
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,594,968	0	259,729	292,156	8,671	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	12,531	0	72	0	0	192.00
192.01	19201	FCMC	0	0	0	0	0	192.01
192.02	19202	ARGOS MEDICAL CENTER	0	0	0	0	0	192.02
192.03	19203	AKRON MEDICAL CENTER	0	0	0	0	0	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	ADVERTISING	7,069	0	1,076	0	0	194.00
194.01	07951	LTC/WELLNESS	0	0	232	0	0	194.01
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)	2,614,568	0	261,109	292,156	8,671	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1313 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part II | Date/Time Prepared: 5/26/2023 7:17 pm

		Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			9.00	10.00	11.00	13.00	14.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.02	00102	AKRON BUILDING						1.02
1.03	00103	ARGOS BUILDING						1.03
1.04	00101	CLAYS BUILDING						1.04
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	34,410					9.00
10.00	01000	DIETARY	33	94,848				10.00
11.00	01100	CAFETERIA	659	0	39,220			11.00
13.00	01300	NURSING ADMINISTRATION	26	0	1,327	67,288		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	211	0	1,026	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	143	0	1,355	5,235	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,053	91,422	4,613	45,025	0	30.00
31.00	03100	INTENSIVE CARE UNIT	825	3,426	841	6,577	0	31.00
43.00	04300	NURSERY	0	0	1,206	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,655	0	2,395	0	0	50.00
51.00	05100	RECOVERY ROOM	2,589	0	1,145	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	339	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,518	0	4,982	0	0	54.00
60.00	06000	LABORATORY	1,295	0	3,982	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,432	0	3,386	0	0	65.00
66.00	06600	PHYSICAL THERAPY	918	0	1,638	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	498	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	107	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,355	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	2,512	0	5,087	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	0	0	0	0	88.04
88.05	08805	RURAL HEALTH CLINIC VI	0	0	0	0	0	88.05
91.00	09100	EMERGENCY	3,980	0	3,599	10,451	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	WOODLAWN MEDICAL PROFESSIONALS	826	0	883	0	0	93.00
93.01	04951	SHAFER MEDICAL CENTER	1,343	0	0	0	0	93.01
93.02	04040	INTERNAL MEDICINE	0	0	633	0	0	93.02
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	34,373	94,848	39,042	67,288	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	37	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	FCMC	0	0	0	0	0	192.01
192.02	19202	ARGOS MEDICAL CENTER	0	0	0	0	0	192.02
192.03	19203	AKRON MEDICAL CENTER	0	0	0	0	0	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	ADVERTISING	0	0	110	0	0	194.00
194.01	07951	LTC/WELLNESS	0	0	68	0	0	194.01
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)	34,410	94,848	39,220	67,288	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1313 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part II | Date/Time Prepared: 5/26/2023 7:17 pm

		Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			15.00	16.00	24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.02	00102	AKRON BUILDING						1.02
1.03	00103	ARGOS BUILDING						1.03
1.04	00101	CLAYS BUILDING						1.04
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	57,352					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	92,580				16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	4,387	534,124	0	534,124	30.00
31.00	03100	INTENSIVE CARE UNIT	0	238	65,054	0	65,054	31.00
43.00	04300	NURSERY	0	187	9,694	0	9,694	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	10,148	231,934	0	231,934	50.00
51.00	05100	RECOVERY ROOM	0	946	128,271	0	128,271	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	195	20,800	0	20,800	52.00
53.00	05300	ANESTHESIOLOGY	0	1,199	4,792	0	4,792	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	20,455	336,577	0	336,577	54.00
60.00	06000	LABORATORY	0	18,472	105,429	0	105,429	60.00
65.00	06500	RESPIRATORY THERAPY	0	5,628	119,350	0	119,350	65.00
66.00	06600	PHYSICAL THERAPY	0	1,413	85,239	0	85,239	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	486	2,360	0	2,360	67.00
68.00	06800	SPEECH PATHOLOGY	0	46	500	0	500	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	840	4,407	0	4,407	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	57,352	12,227	69,579	0	69,579	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	839	70,754	0	70,754	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	3,030	221,051	0	221,051	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	1,478	15,497	0	15,497	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	345	3,386	0	3,386	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	556	42,818	0	42,818	88.04
88.05	08805	RURAL HEALTH CLINIC VI	0	1,981	100,330	0	100,330	88.05
91.00	09100	EMERGENCY	0	4,491	193,632	0	193,632	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
93.00	04950	WOODLAWN MEDICAL PROFESSIONALS	0	625	142,292	0	142,292	93.00
93.01	04951	SHAFER MEDICAL CENTER	0	1,559	69,915	0	69,915	93.01
93.02	04040	INTERNAL MEDICINE	0	809	15,588	0	15,588	93.02
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	57,352	92,580	2,593,373	0	2,593,373	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	37	0	37	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	12,603	0	12,603	192.00
192.01	19201	FCMC	0	0	0	0	0	192.01
192.02	19202	ARGOS MEDICAL CENTER	0	0	0	0	0	192.02
192.03	19203	AKRON MEDICAL CENTER	0	0	0	0	0	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	ADVERTISING	0	0	8,255	0	8,255	194.00
194.01	07951	LTC/WELLNESS	0	0	300	0	300	194.01
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	57,352	92,580	2,614,568	0	2,614,568	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1313 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B-1 | Date/Time Prepared: 5/26/2023 7:17 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	AKRON BUILDING (SQUARE FEET)	ARGOS BUILDING (SQUARE FEET)	CLAYS BUILDING (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	
			1.00	1.02	1.03	1.04	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	108,845					1.00
1.02	00102	AKRON BUILDING	0	3,500				1.02
1.03	00103	ARGOS BUILDING	0	0	7,500			1.03
1.04	00101	CLAYS BUILDING	0	0	0	20,414		1.04
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	26,827,111	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	11,685	400	600	16	3,848,197	5.00
7.00	00700	OPERATION OF PLANT	10,592	240	684	4,657	395,747	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	321	0	0	0	36,448	8.00
9.00	00900	HOUSEKEEPING	1,213	0	0	43	304,873	9.00
10.00	01000	DIETARY	3,850	0	0	0	147,846	10.00
11.00	01100	CAFETERIA	1,484	0	0	0	307,906	11.00
13.00	01300	NURSING ADMINISTRATION	2,553	0	0	0	566,947	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	1,386	0	0	0	408,975	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,320	0	0	4,249	327,543	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	15,096	0	0	0	1,422,278	30.00
31.00	03100	INTENSIVE CARE UNIT	2,058	0	0	0	413,823	31.00
43.00	04300	NURSERY	187	0	0	0	407,595	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,242	0	0	0	782,327	50.00
51.00	05100	RECOVERY ROOM	4,937	0	0	0	415,906	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	794	0	0	0	114,416	52.00
53.00	05300	ANESTHESIOLOGY	137	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,942	0	0	0	1,655,280	54.00
60.00	06000	LABORATORY	2,623	0	0	0	999,022	60.00
65.00	06500	RESPIRATORY THERAPY	4,159	0	0	0	1,045,710	65.00
66.00	06600	PHYSICAL THERAPY	3,151	0	0	0	581,683	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	200,910	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	44,083	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	5,634	749,931	88.00
88.01	08801	RURAL HEALTH CLINIC II	7,677	0	0	0	3,224,568	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	1,507,024	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	0	335,223	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	2,860	0	0	595,643	88.04
88.05	08805	RURAL HEALTH CLINIC VI	0	0	6,216	0	1,143,124	88.05
91.00	09100	EMERGENCY	6,258	0	0	0	1,751,257	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	WOODLAWN MEDICAL PROFESSIONALS	5,723	0	0	0	632,708	93.00
93.01	04951	SHAFER MEDICAL CENTER	0	0	0	5,815	1,648,744	93.01
93.02	04040	INTERNAL MEDICINE	542	0	0	0	746,581	93.02
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	107,930	3,500	7,500	20,414	26,762,318	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	585	0	0	0	0	192.00
192.01	19201	FCMC	0	0	0	0	0	192.01
192.02	19202	ARGOS MEDICAL CENTER	0	0	0	0	0	192.02
192.03	19203	AKRON MEDICAL CENTER	0	0	0	0	0	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	ADVERTISING	330	0	0	0	36,014	194.00
194.01	07951	LTC/WELLNESS	0	0	0	0	28,779	194.01
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)	2,331,476	36,324	81,690	165,078	2,883,737	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	21.420148	10.378286	10.892000	8.086509	0.107493	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)					0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)					0.000000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1313 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B-1 | Date/Time Prepared: 5/26/2023 7:17 pm

	Cost Center Description	CAPITAL RELATED COSTS					
		BLDG & FIXT (SQUARE FEET)	AKRON BUILDING (SQUARE FEET)	ARGOS BUILDING (SQUARE FEET)	CLAYS BUILDING (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	
		1.00	1.02	1.03	1.04	4.00	
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1313 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B-1 | Date/Time Prepared: 5/26/2023 7:17 pm

		Cost Center Description	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDR)	HOUSEKEEPING (HOURS OF SERVIC)	
			5A	5.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.02	00102	AKRON BUILDING						1.02
1.03	00103	ARGOS BUILDING						1.03
1.04	00101	CLAYS BUILDING						1.04
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-8,740,629	45,469,403				5.00
7.00	00700	OPERATION OF PLANT	0	3,077,553	110,470			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	164,691	321	1,629		8.00
9.00	00900	HOUSEKEEPING	0	554,894	1,256	295	148,135	9.00
10.00	01000	DIETARY	0	347,433	3,850	32	140	10.00
11.00	01100	CAFETERIA	0	496,064	1,484	0	2,835	11.00
13.00	01300	NURSING ADMINISTRATION	0	783,109	2,553	0	110	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	3,963,226	1,386	0	910	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,477,357	5,569	0	615	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	2,764,275	15,096	276	34,675	30.00
31.00	03100	INTENSIVE CARE UNIT	0	630,532	2,058	0	3,550	31.00
43.00	04300	NURSERY	0	661,697	187	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	2,788,812	8,242	71	20,040	50.00
51.00	05100	RECOVERY ROOM	0	769,794	4,937	68	11,145	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	201,628	794	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	51,529	137	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,203,555	11,942	346	15,145	54.00
60.00	06000	LABORATORY	0	3,231,379	2,623	0	5,575	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,500,423	4,159	38	6,165	65.00
66.00	06600	PHYSICAL THERAPY	0	904,851	3,151	46	3,950	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	239,621	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	60,354	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	621,026	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	1,410,570	5,634	0	5,835	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	4,474,899	7,677	0	10,815	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	2,441,085	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	529,460	0	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	873,433	2,860	0	0	88.04
88.05	08805	RURAL HEALTH CLINIC VI	0	2,473,369	6,216	0	0	88.05
91.00	09100	EMERGENCY	0	3,148,387	6,258	457	17,135	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	WOODLAWN MEDICAL PROFESSIONALS	0	389,105	5,723	0	3,555	93.00
93.01	04951	SHAFER MEDICAL CENTER	0	802,904	5,815	0	5,780	93.01
93.02	04040	INTERNAL MEDICINE	0	192,063	542	0	0	93.02
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-8,740,629	45,229,078	110,470	1,629	147,975	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	160	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	12,531	0	0	0	192.00
192.01	19201	FCMC	0	0	0	0	0	192.01
192.02	19202	ARGOS MEDICAL CENTER	0	0	0	0	0	192.02
192.03	19203	AKRON MEDICAL CENTER	0	0	0	0	0	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	ADVERTISING	0	187,395	0	0	0	194.00
194.01	07951	LTC/WELLNESS	0	40,399	0	0	0	194.01
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)		8,740,629	3,669,154	207,012	740,767	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)		0.192231	33.214031	127.079190	5.000621	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		261,109	292,156	8,671	34,410	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.005743	2.644664	5.322897	0.232288	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: 15-1313 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B-1 | Date/Time Prepared: 5/26/2023 7:17 pm

		Cost Center Description	DIETARY (PATIENT DAYS)	CAFETERIA (FTES)	NURSING ADMINISTRATION (DIRECT NRS ING HR)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.02	00102	AKRON BUILDING						1.02
1.03	00103	ARGOS BUILDING						1.03
1.04	00101	CLAYS BUILDING						1.04
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	3,848					10.00
11.00	01100	CAFETERIA	0	16,783				11.00
13.00	01300	NURSING ADMINISTRATION	0	568	83,285			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0		14.00
15.00	01500	PHARMACY	0	439	0	0	100	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	580	6,480	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,709	1,974	55,730	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	139	360	8,140	0	0	31.00
43.00	04300	NURSERY	0	516	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,025	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	490	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	145	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,132	0	0	0	54.00
60.00	06000	LABORATORY	0	1,704	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,449	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	701	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	213	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	46	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	100	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	2,176	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	0	0	0	0	88.04
88.05	08805	RURAL HEALTH CLINIC VI	0	0	0	0	0	88.05
91.00	09100	EMERGENCY	0	1,540	12,935	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	WOODLAWN MEDICAL PROFESSIONALS	0	378	0	0	0	93.00
93.01	04951	SHAFER MEDICAL CENTER	0	0	0	0	0	93.01
93.02	04040	INTERNAL MEDICINE	0	271	0	0	0	93.02
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,848	16,707	83,285	0	100	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	FCMC	0	0	0	0	0	192.01
192.02	19202	ARGOS MEDICAL CENTER	0	0	0	0	0	192.02
192.03	19203	AKRON MEDICAL CENTER	0	0	0	0	0	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	ADVERTISING	0	47	0	0	0	194.00
194.01	07951	LTC/WELLNESS	0	29	0	0	0	194.01
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)	546,861	654,890	1,041,156	0	4,792,797	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	142.115644	39.021033	12.501123	0.000000	47,927.970000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	94,848	39,220	67,288	0	57,352	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	24.648649	2.336889	0.807925	0.000000	573.520000	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: 15-1313 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B-1 | Date/Time Prepared: 5/26/2023 7:17 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)		
			16.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
1.02	00102	AKRON BUILDING			1.02
1.03	00103	ARGOS BUILDING			1.03
1.04	00101	CLAYS BUILDING			1.04
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	159,257,392		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	7,550,996		30.00
31.00	03100	INTENSIVE CARE UNIT	409,597		31.00
43.00	04300	NURSERY	321,612		43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	17,467,110		50.00
51.00	05100	RECOVERY ROOM	1,628,559		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	335,188		52.00
53.00	05300	ANESTHESIOLOGY	2,062,864		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	35,113,871		54.00
60.00	06000	LABORATORY	31,792,871		60.00
65.00	06500	RESPIRATORY THERAPY	9,687,010		65.00
66.00	06600	PHYSICAL THERAPY	2,432,696		66.00
67.00	06700	OCCUPATIONAL THERAPY	836,764		67.00
68.00	06800	SPEECH PATHOLOGY	80,013		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,445,304		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	21,045,252		73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	1,443,555		88.00
88.01	08801	RURAL HEALTH CLINIC II	5,215,701		88.01
88.02	08802	RURAL HEALTH CLINIC III	2,544,344		88.02
88.03	08803	RURAL HEALTH CLINIC IV	594,270		88.03
88.04	08804	RURAL HEALTH CLINIC V	957,524		88.04
88.05	08805	RURAL HEALTH CLINIC VI	3,410,185		88.05
91.00	09100	EMERGENCY	7,730,043		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
93.00	04950	WOODLAWN MEDICAL PROFESSIONALS	1,075,974		93.00
93.01	04951	SHAFER MEDICAL CENTER	2,683,592		93.01
93.02	04040	INTERNAL MEDICINE	1,392,497		93.02
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	159,257,392		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0		190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0		192.00
192.01	19201	FCMC	0		192.01
192.02	19202	ARGOS MEDICAL CENTER	0		192.02
192.03	19203	AKRON MEDICAL CENTER	0		192.03
193.00	19300	NONPAID WORKERS	0		193.00
194.00	07950	ADVERTISING	0		194.00
194.01	07951	LTC/WELLNESS	0		194.01
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)	2,053,034		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.012891		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	92,580		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000581		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: 15-1313 | Period: From 01/01/2022 To 12/31/2022 | Worksheet C Part I Date/Time Prepared: 5/26/2023 7:17 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	5,403,688		5,403,688	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	978,687		978,687	0	0	31.00
43.00	04300	NURSERY	819,388		819,388	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,973,059		3,973,059	0	0	50.00
51.00	05100	RECOVERY ROOM	1,186,237		1,186,237	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	276,738		276,738	0	0	52.00
53.00	05300	ANESTHESIOLOGY	92,576		92,576	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,871,616		4,871,616	0	0	54.00
60.00	06000	LABORATORY	4,443,882		4,443,882	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	2,144,062	0	2,144,062	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,267,760	0	1,267,760	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	304,782	0	304,782	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	74,782	0	74,782	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0		0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	759,037		759,037	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,064,091		5,064,091	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,916,641		1,916,641	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	5,796,325		5,796,325	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	2,943,136		2,943,136	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	638,900		638,900	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	1,148,669		1,148,669	0	0	88.04
88.05	08805	RURAL HEALTH CLINIC VI	3,199,246		3,199,246	0	0	88.05
91.00	09100	EMERGENCY	4,426,661		4,426,661	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,858,860		1,858,860		0	92.00
93.00	04950	WOODLAWN MEDICAL PROFESSIONALS	700,384		700,384	0	0	93.00
93.01	04951	SHAFER MEDICAL CENTER	1,213,885		1,213,885	0	0	93.01
93.02	04040	INTERNAL MEDICINE	275,511		275,511	0	0	93.02
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	55,778,603	0	55,778,603	0	0	200.00
201.00		Less Observation Beds	1,858,860		1,858,860		0	201.00
202.00		Total (see instructions)	53,919,743	0	53,919,743	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1313 | Period: From 01/01/2022 To 12/31/2022 | Worksheet C Part I Date/Time Prepared: 5/26/2023 7:17 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Charges: Inpatient	Charges: Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,105,981		3,105,981			30.00
31.00	03100	INTENSIVE CARE UNIT	409,597		409,597			31.00
43.00	04300	NURSERY	321,612		321,612			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,570,282	14,896,828	17,467,110	0.227459	0.000000	50.00
51.00	05100	RECOVERY ROOM	236,565	1,391,994	1,628,559	0.728397	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	221,840	113,348	335,188	0.825620	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	169,234	1,893,630	2,062,864	0.044877	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	862,922	34,250,949	35,113,871	0.138738	0.000000	54.00
60.00	06000	LABORATORY	2,139,112	29,653,759	31,792,871	0.139776	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	2,385,340	7,301,670	9,687,010	0.221334	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	257,768	2,174,928	2,432,696	0.521134	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	105,931	730,833	836,764	0.364239	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	11,470	68,543	80,013	0.934623	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0.000000	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	526,386	918,918	1,445,304	0.525175	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,261,138	17,784,114	21,045,252	0.240629	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	1,443,555	1,443,555			88.00
88.01	08801	RURAL HEALTH CLINIC II	0	5,215,701	5,215,701			88.01
88.02	08802	RURAL HEALTH CLINIC III	0	2,544,344	2,544,344			88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	594,270	594,270			88.03
88.04	08804	RURAL HEALTH CLINIC V	0	957,524	957,524			88.04
88.05	08805	RURAL HEALTH CLINIC VI	0	3,410,185	3,410,185			88.05
91.00	09100	EMERGENCY	165,143	7,564,900	7,730,043	0.572657	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	472,051	3,972,964	4,445,015	0.418190	0.000000	92.00
93.00	04950	WOODLAWN MEDICAL PROFESSIONALS	0	1,075,974	1,075,974	0.650930	0.000000	93.00
93.01	04951	SHAFER MEDICAL CENTER	0	2,683,592	2,683,592	0.452336	0.000000	93.01
93.02	04040	INTERNAL MEDICINE	0	1,392,497	1,392,497	0.197854	0.000000	93.02
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	17,222,372	142,035,020	159,257,392			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	17,222,372	142,035,020	159,257,392			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1313 | Period: From 01/01/2022 To 12/31/2022 | Worksheet C Part I Date/Time Prepared: 5/26/2023 7:17 pm

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
51.00	05100	RECOVERY ROOM	0.000000		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
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 PATIENT	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC			88.00
88.01	08801	RURAL HEALTH CLINIC II			88.01
88.02	08802	RURAL HEALTH CLINIC III			88.02
88.03	08803	RURAL HEALTH CLINIC IV			88.03
88.04	08804	RURAL HEALTH CLINIC V			88.04
88.05	08805	RURAL HEALTH CLINIC VI			88.05
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
93.00	04950	WOODLAWN MEDICAL PROFESSIONALS	0.000000		93.00
93.01	04951	SHAFER MEDICAL CENTER	0.000000		93.01
93.02	04040	INTERNAL MEDICINE	0.000000		93.02
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1313 | Period: From 01/01/2022 To 12/31/2022 | Worksheet C Part I Date/Time Prepared: 5/26/2023 7:17 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,403,688		5,403,688	0	5,403,688	30.00
31.00	03100	INTENSIVE CARE UNIT	978,687		978,687	0	978,687	31.00
43.00	04300	NURSERY	819,388		819,388	0	819,388	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,973,059		3,973,059	0	3,973,059	50.00
51.00	05100	RECOVERY ROOM	1,186,237		1,186,237	0	1,186,237	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	276,738		276,738	0	276,738	52.00
53.00	05300	ANESTHESIOLOGY	92,576		92,576	0	92,576	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,871,616		4,871,616	0	4,871,616	54.00
60.00	06000	LABORATORY	4,443,882		4,443,882	0	4,443,882	60.00
65.00	06500	RESPIRATORY THERAPY	2,144,062	0	2,144,062	0	2,144,062	65.00
66.00	06600	PHYSICAL THERAPY	1,267,760	0	1,267,760	0	1,267,760	66.00
67.00	06700	OCCUPATIONAL THERAPY	304,782	0	304,782	0	304,782	67.00
68.00	06800	SPEECH PATHOLOGY	74,782	0	74,782	0	74,782	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0		0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	759,037		759,037	0	759,037	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,064,091		5,064,091	0	5,064,091	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,916,641		1,916,641	0	1,916,641	88.00
88.01	08801	RURAL HEALTH CLINIC II	5,796,325		5,796,325	0	5,796,325	88.01
88.02	08802	RURAL HEALTH CLINIC III	2,943,136		2,943,136	0	2,943,136	88.02
88.03	08803	RURAL HEALTH CLINIC IV	638,900		638,900	0	638,900	88.03
88.04	08804	RURAL HEALTH CLINIC V	1,148,669		1,148,669	0	1,148,669	88.04
88.05	08805	RURAL HEALTH CLINIC VI	3,199,246		3,199,246	0	3,199,246	88.05
91.00	09100	EMERGENCY	4,426,661		4,426,661	0	4,426,661	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,858,860		1,858,860		1,858,860	92.00
93.00	04950	WOODLAWN MEDICAL PROFESSIONALS	700,384		700,384	0	700,384	93.00
93.01	04951	SHAFER MEDICAL CENTER	1,213,885		1,213,885	0	1,213,885	93.01
93.02	04040	INTERNAL MEDICINE	275,511		275,511	0	275,511	93.02
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	55,778,603	0	55,778,603	0	55,778,603	200.00
201.00		Less Observation Beds	1,858,860		1,858,860		1,858,860	201.00
202.00		Total (see instructions)	53,919,743	0	53,919,743	0	53,919,743	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1313 | Period: From 01/01/2022 To 12/31/2022 | Worksheet C Part I Date/Time Prepared: 5/26/2023 7:17 pm

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,105,981		3,105,981			30.00
31.00	03100	INTENSIVE CARE UNIT	409,597		409,597			31.00
43.00	04300	NURSERY	321,612		321,612			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,570,282	14,896,828	17,467,110	0.227459	0.000000	50.00
51.00	05100	RECOVERY ROOM	236,565	1,391,994	1,628,559	0.728397	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	221,840	113,348	335,188	0.825620	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	169,234	1,893,630	2,062,864	0.044877	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	862,922	34,250,949	35,113,871	0.138738	0.000000	54.00
60.00	06000	LABORATORY	2,139,112	29,653,759	31,792,871	0.139776	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	2,385,340	7,301,670	9,687,010	0.221334	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	257,768	2,174,928	2,432,696	0.521134	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	105,931	730,833	836,764	0.364239	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	11,470	68,543	80,013	0.934623	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0.000000	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	526,386	918,918	1,445,304	0.525175	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,261,138	17,784,114	21,045,252	0.240629	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	1,443,555	1,443,555	1.327723	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	5,215,701	5,215,701	1.111322	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	2,544,344	2,544,344	1.156737	0.000000	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	594,270	594,270	1.075101	0.000000	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	957,524	957,524	1.199624	0.000000	88.04
88.05	08805	RURAL HEALTH CLINIC VI	0	3,410,185	3,410,185	0.938144	0.000000	88.05
91.00	09100	EMERGENCY	165,143	7,564,900	7,730,043	0.572657	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	472,051	3,972,964	4,445,015	0.418190	0.000000	92.00
93.00	04950	WOODLAWN MEDICAL PROFESSIONALS	0	1,075,974	1,075,974	0.650930	0.000000	93.00
93.01	04951	SHAFER MEDICAL CENTER	0	2,683,592	2,683,592	0.452336	0.000000	93.01
93.02	04040	INTERNAL MEDICINE	0	1,392,497	1,392,497	0.197854	0.000000	93.02
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	17,222,372	142,035,020	159,257,392			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	17,222,372	142,035,020	159,257,392			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1313 | Period: From 01/01/2022 To 12/31/2022 | Worksheet C Part I Date/Time Prepared: 5/26/2023 7:17 pm

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
51.00	05100	RECOVERY ROOM	0.000000		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
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 PATIENT	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000		88.02
88.03	08803	RURAL HEALTH CLINIC IV	0.000000		88.03
88.04	08804	RURAL HEALTH CLINIC V	0.000000		88.04
88.05	08805	RURAL HEALTH CLINIC VI	0.000000		88.05
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
93.00	04950	WOODLAWN MEDICAL PROFESSIONALS	0.000000		93.00
93.01	04951	SHAFER MEDICAL CENTER	0.000000		93.01
93.02	04040	INTERNAL MEDICINE	0.000000		93.02
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-1313 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part II Date/Time Prepared: 5/26/2023 7:17 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	231,934	17,467,110	0.013278	534,968	7,103	50.00
51.00	05100	RECOVERY ROOM	128,271	1,628,559	0.078763	37,338	2,941	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	20,800	335,188	0.062055	0	0	52.00
53.00	05300	ANESTHESIOLOGY	4,792	2,062,864	0.002323	33,708	78	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	336,577	35,113,871	0.009585	300,176	2,877	54.00
60.00	06000	LABORATORY	105,429	31,792,871	0.003316	726,803	2,410	60.00
65.00	06500	RESPIRATORY THERAPY	119,350	9,687,010	0.012321	901,256	11,104	65.00
66.00	06600	PHYSICAL THERAPY	85,239	2,432,696	0.035039	94,599	3,315	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,360	836,764	0.002820	26,196	74	67.00
68.00	06800	SPEECH PATHOLOGY	500	80,013	0.006249	7,275	45	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,407	1,445,304	0.003049	188,807	576	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	69,579	21,045,252	0.003306	761,590	2,518	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	70,754	1,443,555	0.049014	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	221,051	5,215,701	0.042382	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	15,497	2,544,344	0.006091	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	3,386	594,270	0.005698	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	42,818	957,524	0.044717	0	0	88.04
88.05	08805	RURAL HEALTH CLINIC VI	100,330	3,410,185	0.029421	0	0	88.05
91.00	09100	EMERGENCY	193,632	7,730,043	0.025049	2,117	53	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	183,737	4,445,015	0.041336	22,906	947	92.00
93.00	04950	WOODLAWN MEDICAL PROFESSIONALS	142,292	1,075,974	0.132245	0	0	93.00
93.01	04951	SHAFER MEDICAL CENTER	69,915	2,683,592	0.026053	0	0	93.01
93.02	04040	INTERNAL MEDICINE	15,588	1,392,497	0.011194	0	0	93.02
200.00		Total (lines 50 through 199)	2,168,238	155,420,202		3,637,739	34,041	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1313 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part IV Date/Time Prepared: 5/26/2023 7:17 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
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 PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	0	0	0	0	88.04
88.05	08805	RURAL HEALTH CLINIC VI	0	0	0	0	0	88.05
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
93.00	04950	WOODLAWN MEDICAL PROFESSIONALS	0	0	0	0	0	93.00
93.01	04951	SHAFER MEDICAL CENTER	0	0	0	0	0	93.01
93.02	04040	INTERNAL MEDICINE	0	0	0	0	0	93.02
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: 15-1313 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part IV Date/Time Prepared: 5/26/2023 7:17 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	17,467,110	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	1,628,559	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	335,188	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	2,062,864	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	35,113,871	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	31,792,871	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	9,687,010	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,432,696	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	836,764	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	80,013	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,445,304	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	21,045,252	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	1,443,555	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	5,215,701	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	2,544,344	0.000000	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	594,270	0.000000	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	0	0	957,524	0.000000	88.04
88.05	08805	RURAL HEALTH CLINIC VI	0	0	0	3,410,185	0.000000	88.05
91.00	09100	EMERGENCY	0	0	0	7,730,043	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	4,445,015	0.000000	92.00
93.00	04950	WOODLAWN MEDICAL PROFESSIONALS	0	0	0	1,075,974	0.000000	93.00
93.01	04951	SHAFER MEDICAL CENTER	0	0	0	2,683,592	0.000000	93.01
93.02	04040	INTERNAL MEDICINE	0	0	0	1,392,497	0.000000	93.02
200.00		Total (lines 50 through 199)	0	0	0	155,420,202		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1313 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part IV Date/Time Prepared: 5/26/2023 7:17 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	534,968	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	37,338	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	33,708	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	300,176	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	726,803	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	901,256	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	94,599	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	26,196	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	7,275	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	188,807	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	761,590	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000	0	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0.000000	0	0	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	0.000000	0	0	0	0	88.04
88.05	08805	RURAL HEALTH CLINIC VI	0.000000	0	0	0	0	88.05
91.00	09100	EMERGENCY	0.000000	2,117	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	22,906	0	0	0	92.00
93.00	04950	WOODLAWN MEDICAL PROFESSIONALS	0.000000	0	0	0	0	93.00
93.01	04951	SHAFER MEDICAL CENTER	0.000000	0	0	0	0	93.01
93.02	04040	INTERNAL MEDICINE	0.000000	0	0	0	0	93.02
200.00		Total (lines 50 through 199)		3,637,739	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1313 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part V Date/Time Prepared: 5/26/2023 7:17 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	0.227459	0	1,695,889	0	0	50.00
51.00	05100	RECOVERY ROOM	0.728397	0	161,164	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.825620	0	1,812	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.044877	0	317,920	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.138738	0	7,371,113	0	0	54.00
60.00	06000	LABORATORY	0.139776	0	5,860,975	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.221334	0	1,576,935	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.521134	0	542,357	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.364239	0	205,556	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.934623	0	1,471	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.525175	0	150,872	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.240629	0	7,447,107	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC						88.00
88.01	08801	RURAL HEALTH CLINIC II						88.01
88.02	08802	RURAL HEALTH CLINIC III						88.02
88.03	08803	RURAL HEALTH CLINIC IV						88.03
88.04	08804	RURAL HEALTH CLINIC V						88.04
88.05	08805	RURAL HEALTH CLINIC VI						88.05
91.00	09100	EMERGENCY	0.572657	0	1,275,151	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.418190	0	489,833	0	0	92.00
93.00	04950	WOODLAWN MEDICAL PROFESSIONALS	0.650930	0	0	0	0	93.00
93.01	04951	SHAFER MEDICAL CENTER	0.452336	0	0	0	0	93.01
93.02	04040	INTERNAL MEDICINE	0.197854	0	0	0	0	93.02
200.00		Subtotal (see instructions)		0	27,098,155	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	27,098,155	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1313 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part V Date/Time Prepared: 5/26/2023 7:17 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	385,745	0		50.00
51.00	05100	RECOVERY ROOM	117,391	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,496	0		52.00
53.00	05300	ANESTHESIOLOGY	14,267	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,022,653	0		54.00
60.00	06000	LABORATORY	819,224	0		60.00
65.00	06500	RESPIRATORY THERAPY	349,029	0		65.00
66.00	06600	PHYSICAL THERAPY	282,641	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	74,872	0		67.00
68.00	06800	SPEECH PATHOLOGY	1,375	0		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	79,234	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,791,990	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC				88.00
88.01	08801	RURAL HEALTH CLINIC II				88.01
88.02	08802	RURAL HEALTH CLINIC III				88.02
88.03	08803	RURAL HEALTH CLINIC IV				88.03
88.04	08804	RURAL HEALTH CLINIC V				88.04
88.05	08805	RURAL HEALTH CLINIC VI				88.05
91.00	09100	EMERGENCY	730,224	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	204,843	0		92.00
93.00	04950	WOODLAWN MEDICAL PROFESSIONALS	0	0		93.00
93.01	04951	SHAFER MEDICAL CENTER	0	0		93.01
93.02	04040	INTERNAL MEDICINE	0	0		93.02
200.00		Subtotal (see instructions)	5,874,984	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	5,874,984	0		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1313 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-1 | Date/Time Prepared: 5/26/2023 7:17 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)	3,586	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,268	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)	2,067	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	205	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	113	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)	766	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)	205	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)	5,403,688	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	28,300	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)	345,593	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	5,058,095	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)	5,058,095	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,547.77	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,185,592	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	1,185,592	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1313 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-1 | Date/Time Prepared: 5/26/2023 7:17 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	978,687	139	7,040.91	58	408,373	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)	851,957	48.00
48.01	Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)	0	48.01
49.00	Total Program inpatient costs (sum of lines 41 through 48.01)(see instructions)	2,445,922	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)	317,293	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	317,293	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	1,201	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,547.76	88.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-1313	Period: From 01/01/2022 To 12/31/2022	Worksheet D-1 Date/Time Prepared: 5/26/2023 7:17 pm
	Title XVIII	Hospital	Cost

	Cost Center Description		
		1.00	
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,858,860	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	534,124	5,403,688	0.098844	1,858,860	183,737	90.00
91.00	Nursing Program cost	0	5,403,688	0.000000	1,858,860	0	91.00
92.00	Allied health cost	0	5,403,688	0.000000	1,858,860	0	92.00
93.00	All other Medical Education	0	5,403,688	0.000000	1,858,860	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1313 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-1 | Date/Time Prepared: 5/26/2023 7:17 pm

Title XIX | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,586	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,268	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)	2,067	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	205	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	113	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)	60	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)	371	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)	5,403,688	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	28,300	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)	345,593	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	5,058,095	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)	5,058,095	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,547.77	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	92,866	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)	92,866	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1313 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-1 | Date/Time Prepared: 5/26/2023 7:17 pm

Title XIX | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	819,388	371	2,208.59	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	978,687	139	7,040.91	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)	65,491	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)	158,357	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
55.01	Permanent adjustment amount per discharge	0.00	55.01
55.02	Adjustment amount per discharge (contractor use only)	0.00	55.02
56.00	Target amount (line 54 x sum of lines 55, 55.01, and 55.02)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)	0.00	59.00
60.00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)	0.00	60.00
61.00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	1,201	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,547.76	88.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-1313	Period: From 01/01/2022 To 12/31/2022	Worksheet D-1 Date/Time Prepared: 5/26/2023 7:17 pm
	Title XIX	Hospital	Cost

	Cost Center Description		
		1.00	
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,858,860	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	534,124	5,403,688	0.098844	1,858,860	183,737	90.00
91.00	Nursing Program cost	0	5,403,688	0.000000	1,858,860	0	91.00
92.00	Allied health cost	0	5,403,688	0.000000	1,858,860	0	92.00
93.00	All other Medical Education	0	5,403,688	0.000000	1,858,860	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1313 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-3 | Date/Time Prepared: 5/26/2023 7:17 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		1,097,431		30.00
31.00	03100	INTENSIVE CARE UNIT		172,842		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.227459	534,968	121,683	50.00
51.00	05100	RECOVERY ROOM	0.728397	37,338	27,197	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.825620	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.044877	33,708	1,513	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.138738	300,176	41,646	54.00
60.00	06000	LABORATORY	0.139776	726,803	101,590	60.00
65.00	06500	RESPIRATORY THERAPY	0.221334	901,256	199,479	65.00
66.00	06600	PHYSICAL THERAPY	0.521134	94,599	49,299	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.364239	26,196	9,542	67.00
68.00	06800	SPEECH PATHOLOGY	0.934623	7,275	6,799	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.525175	188,807	99,157	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.240629	761,590	183,261	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000		0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0.000000		0	88.03
88.04	08804	RURAL HEALTH CLINIC V	0.000000		0	88.04
88.05	08805	RURAL HEALTH CLINIC VI	0.000000		0	88.05
91.00	09100	EMERGENCY	0.572657	2,117	1,212	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.418190	22,906	9,579	92.00
93.00	04950	WOODLAWN MEDICAL PROFESSIONALS	0.650930	0	0	93.00
93.01	04951	SHAFER MEDICAL CENTER	0.452336	0	0	93.01
93.02	04040	INTERNAL MEDICINE	0.197854	0	0	93.02
200.00		Total (sum of lines 50 through 94 and 96 through 98)		3,637,739	851,957	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)		3,637,739		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-1313 | Component CCN: 15-Z313 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-3 | Date/Time Prepared: 5/26/2023 7:17 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	0.227459	1,735	395	50.00
51.00	05100	RECOVERY ROOM	0.728397	1	1	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.825620	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.044877	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.138738	14,495	2,011	54.00
60.00	06000	LABORATORY	0.139776	17,423	2,435	60.00
65.00	06500	RESPIRATORY THERAPY	0.221334	83,755	18,538	65.00
66.00	06600	PHYSICAL THERAPY	0.521134	47,482	24,744	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.364239	38,553	14,043	67.00
68.00	06800	SPEECH PATHOLOGY	0.934623	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.525175	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.240629	45,117	10,856	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000		0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0.000000		0	88.03
88.04	08804	RURAL HEALTH CLINIC V	0.000000		0	88.04
88.05	08805	RURAL HEALTH CLINIC VI	0.000000		0	88.05
91.00	09100	EMERGENCY	0.572657	11	6	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.418190	607	254	92.00
93.00	04950	WOODLAWN MEDICAL PROFESSIONALS	0.650930	0	0	93.00
93.01	04951	SHAFER MEDICAL CENTER	0.452336	0	0	93.01
93.02	04040	INTERNAL MEDICINE	0.197854	0	0	93.02
200.00		Total (sum of lines 50 through 94 and 96 through 98)		249,179	73,283	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)		249,179		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1313 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-3 | Date/Time Prepared: 5/26/2023 7:17 pm

Title XIX | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		151,960		30.00
31.00	03100	INTENSIVE CARE UNIT		4,260		31.00
43.00	04300	NURSERY		0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.227459	87,231	19,841	50.00
51.00	05100	RECOVERY ROOM	0.728397	9,107	6,634	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.825620	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.044877	6,123	275	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.138738	7,751	1,075	54.00
60.00	06000	LABORATORY	0.139776	61,056	8,534	60.00
65.00	06500	RESPIRATORY THERAPY	0.221334	40,070	8,869	65.00
66.00	06600	PHYSICAL THERAPY	0.521134	967	504	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.364239	172	63	67.00
68.00	06800	SPEECH PATHOLOGY	0.934623	167	156	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.525175	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.240629	58,067	13,973	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	1.327723	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	1.111322	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	1.156737	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	1.075101	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	1.199624	0	0	88.04
88.05	08805	RURAL HEALTH CLINIC VI	0.938144	0	0	88.05
91.00	09100	EMERGENCY	0.572657	9,721	5,567	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.418190	0	0	92.00
93.00	04950	WOODLAWN MEDICAL PROFESSIONALS	0.650930	0	0	93.00
93.01	04951	SHAFER MEDICAL CENTER	0.452336	0	0	93.01
93.02	04040	INTERNAL MEDICINE	0.197854	0	0	93.02
200.00		Total (sum of lines 50 through 94 and 96 through 98)		280,432	65,491	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)		280,432		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1313	Period: From 01/01/2022 To 12/31/2022	Worksheet E Part B Date/Time Prepared: 5/26/2023 7:17 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	5,874,984	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)	5,874,984	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)	5,933,734	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	76,212	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	4,219,355	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)	1,638,167	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)	1,638,167	30.00
31.00	Primary payer payments	578	31.00
32.00	Subtotal (line 30 minus line 31)	1,637,589	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)	313,287	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	203,637	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	154,669	36.00
37.00	Subtotal (see instructions)	1,841,226	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.75	N95 respirator payment adjustment amount (see instructions)	0	39.75
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	1,841,226	40.00
40.01	Sequestration adjustment (see instructions)	23,199	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	2,169,552	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)	-351,525	43.00
43.01	Balance due provider/program-PARHM (see instructions)		43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1313	Period: From 01/01/2022 To 12/31/2022	Worksheet E Part B Date/Time Prepared: 5/26/2023 7:17 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: 15-1313 | Period: From 01/01/2022 To 12/31/2022 | Worksheet E-1 Part I Date/Time Prepared: 5/26/2023 7:17 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		2,663,041		2,169,552	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	12/05/2022	33,500		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)		33,500		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)		2,696,541		2,169,552	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		507,502		351,525	6.02
7.00	Total Medicare program liability (see instructions)		2,189,039		1,818,027	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: 15-1313 | Component CCN: 15-Z313 | Period: From 01/01/2022 To 12/31/2022 | Worksheet E-1 Part I | Date/Time Prepared: 5/26/2023 7:17 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		456,338		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		456,338		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		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		72,588		0	6.02
7.00	Total Medicare program liability (see instructions)		383,750		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: 15-1313	Period: From 01/01/2022 To 12/31/2022	Worksheet E-1 Part II Date/Time Prepared: 5/26/2023 7:17 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: 15-1313 | Component CCN: 15-Z313 | Period: From 01/01/2022 To 12/31/2022 | Worksheet E-2 | Date/Time Prepared: 5/26/2023 7:17 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)	320,466	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)	74,016	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	205	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)	394,482	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	394,482	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)	394,482	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	5,835	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (see instructions)	388,647	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)	388,647	0	19.00
19.01	Sequestration adjustment (see instructions)	4,897	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	456,338	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)	-72,588	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: 15-1313	Period: From 01/01/2022 To 12/31/2022	Worksheet E-3 Part V Date/Time Prepared: 5/26/2023 7:17 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	2,445,922	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)	0	2.00
3.00	Organ acquisition	0	3.00
3.01	Cellular therapy acquisition cost (see instructions)	0	3.01
4.00	Subtotal (sum of lines 1 through 3.01)	2,445,922	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	2,470,381	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	2,470,381	19.00
20.00	Deductibles (exclude professional component)	273,568	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	2,196,813	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	2,196,813	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	31,014	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	20,159	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	8,661	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	2,216,972	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)	2,216,972	30.00
30.01	Sequestration adjustment (see instructions)	27,933	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	2,696,541	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)	-507,502	33.00
33.01	Balance due provider/program-PARHM or CHART (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01)		33.01
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1313	Period: From 01/01/2022 To 12/31/2022	Worksheet E-3 Part VII Date/Time Prepared: 5/26/2023 7:17 pm
	Title XIX	Hospital	Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	158,357		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant programs only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	158,357	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	158,357	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	156,221		8.00
9.00	Ancillary service charges	280,432	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	436,653	0	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	436,653	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	278,296	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	158,357	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	158,357	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	158,357	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	158,357	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	158,357	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	158,357	0	40.00
41.00	Interim payments	159,407	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	-1,050	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 15-1313 | Period: From 01/01/2022 To 12/31/2022 | Worksheet G | Date/Time Prepared: 5/26/2023 7:17 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	9,054,689	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	24,340,028	0	0	0	4.00
5.00	Other receivable	2,299,779	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-16,474,806	0	0	0	6.00
7.00	Inventory	983,834	0	0	0	7.00
8.00	Prepaid expenses	271,139	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	20,474,663	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	596,216	0	0	0	12.00
13.00	Land improvements	513,782	0	0	0	13.00
14.00	Accumulated depreciation	-468,485	0	0	0	14.00
15.00	Buildings	29,635,140	0	0	0	15.00
16.00	Accumulated depreciation	-17,447,459	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	16,309,970	0	0	0	23.00
24.00	Accumulated depreciation	-12,041,580	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)	17,097,584	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	10,651,643	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	1,920,398	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	12,572,041	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	50,144,288	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	3,545,063	0	0	0	37.00
38.00	Salaries, wages, and fees payable	2,088,998	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	675,253	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	1,925,208	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	8,234,522	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	7,922,818	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)	7,922,818	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	16,157,340	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	33,986,948				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)	33,986,948	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	50,144,288	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-1313 | Period: From 01/01/2022 To 12/31/2022 | Worksheet G-1 | Date/Time Prepared: 5/26/2023 7:17 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		35,095,753		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-1,108,805				2.00
3.00	Total (sum of line 1 and line 2)		33,986,948		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		33,986,948		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)		33,986,948		0		19.00

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 15-1313 | Period: From 01/01/2022 To 12/31/2022 | Worksheet G-2 Parts I & II | Date/Time Prepared: 5/26/2023 7:17 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	4,147,635		4,147,635	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)	4,147,635		4,147,635	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	472,615		472,615	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)	472,615		472,615	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	4,620,250		4,620,250	17.00
18.00	Ancillary services	12,671,748	126,723,841	139,395,589	18.00
19.00	Outpatient services	0	16,648	16,648	19.00
20.00	RURAL HEALTH CLINIC	0	1,443,555	1,443,555	20.00
20.01	RURAL HEALTH CLINIC II	0	5,215,701	5,215,701	20.01
20.02	RURAL HEALTH CLINIC III	0	2,544,344	2,544,344	20.02
20.03	RURAL HEALTH CLINIC IV	0	594,270	594,270	20.03
20.04	RURAL HEALTH CLINIC V	0	957,524	957,524	20.04
20.05	RURAL HEALTH CLINIC VI	0	3,410,185	3,410,185	20.05
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER OUTPATIENT	0	1,075,974	1,075,974	27.00
27.01	PROFESSIONAL FEES	0	4,163,215	4,163,215	27.01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	17,291,998	146,145,257	163,437,255	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		63,941,049		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	ADJUST	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)		63,941,049		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-1313 | Period: From 01/01/2022 To 12/31/2022 | Worksheet G-3 | Date/Time Prepared: 5/26/2023 7:17 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	163,437,255	1.00
2.00	Less contractual allowances and discounts on patients' accounts	109,618,236	2.00
3.00	Net patient revenues (line 1 minus line 2)	53,819,019	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	63,941,049	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-10,122,030	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	94,872	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	127,077	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	9	21.00
22.00	Rental of hospital space	2,950	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER OPERATING INCOME	8,800,562	24.00
24.01	GAIN/LOSS DISP ASSET-MISC	-20,660	24.01
24.02	DONATIONS FROM FOUNDATION	8,415	24.02
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	9,013,225	25.00
26.00	Total (line 5 plus line 25)	-1,108,805	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)	-1,108,805	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1313 | Component CCN: 15-8551 | Period: From 01/01/2022 To 12/31/2022 | Worksheet M-1 | Date/Time Prepared: 5/26/2023 7:17 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	451,521	0	451,521	0	451,521	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	78,610	0	78,610	0	78,610	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	40,844	0	40,844	0	40,844	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	114,186	0	114,186	0	114,186	9.00
10.00	Subtotal (sum of lines 1 through 9)	685,161	0	685,161	0	685,161	10.00
11.00	Physician Services Under Agreement	0	602,147	602,147	0	602,147	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	602,147	602,147	0	602,147	14.00
15.00	Medical Supplies	0	1,202	1,202	0	1,202	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	1,202	1,202	0	1,202	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	685,161	603,349	1,288,510	0	1,288,510	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	7,801	7,801	0	7,801	29.00
30.00	Administrative Costs	49,662	159,671	209,333	15,113	224,446	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	49,662	167,472	217,134	15,113	232,247	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	734,823	770,821	1,505,644	15,113	1,520,757	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1313 | Component CCN: 15-8551 | Period: From 01/01/2022 To 12/31/2022 | Worksheet M-1 | Date/Time Prepared: 5/26/2023 7:17 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	-226,599	224,922		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	-9,759	68,851		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	40,844		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	114,186		9.00
10.00	Subtotal (sum of lines 1 through 9)	-236,358	448,803		10.00
11.00	Physician Services Under Agreement	0	602,147		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	602,147		14.00
15.00	Medical Supplies	0	1,202		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	1,202		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-236,358	1,052,152		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	0		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	7,801		29.00
30.00	Administrative Costs	0	224,446		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	232,247		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-236,358	1,284,399		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1313 | Component CCN: 15-8552 | Period: From 01/01/2022 To 12/31/2022 | Worksheet M-1 | Date/Time Prepared: 5/26/2023 7:17 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	2,428,243	5,808	2,434,051	0	2,434,051	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	218,721	0	218,721	0	218,721	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	252,023	0	252,023	0	252,023	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	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	2,898,987	5,808	2,904,795	0	2,904,795	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	428,203	428,203	0	428,203	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	428,203	428,203	0	428,203	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	2,898,987	434,011	3,332,998	0	3,332,998	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	564,198	564,198	-564,198	0	29.00
30.00	Administrative Costs	369,493	527,477	896,970	-43,936	853,034	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	369,493	1,091,675	1,461,168	-608,134	853,034	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	3,268,480	1,525,686	4,794,166	-608,134	4,186,032	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1313 | Period: From 01/01/2022 To 12/31/2022 | Worksheet M-1

Component CCN: 15-8552 | Date/Time Prepared: 5/26/2023 7:17 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	-218,102	2,215,949		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	-4,091	214,630		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	252,023		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	0		9.00
10.00	Subtotal (sum of lines 1 through 9)	-222,193	2,682,602		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	428,203		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	428,203		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-222,193	3,110,805		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	0		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	0		29.00
30.00	Administrative Costs	0	853,034		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	853,034		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-222,193	3,963,839		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1313 | Component CCN: 15-8550 | Period: From 01/01/2022 To 12/31/2022 | Worksheet M-1 | Date/Time Prepared: 5/26/2023 7:17 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	1,041,563	4,398	1,045,961	0	1,045,961	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	187,807	0	187,807	0	187,807	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	80,627	0	80,627	0	80,627	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	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	1,309,997	4,398	1,314,395	0	1,314,395	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	111,449	111,449	0	111,449	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	111,449	111,449	0	111,449	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,309,997	115,847	1,425,844	0	1,425,844	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	180,882	180,882	-40,086	140,796	29.00
30.00	Administrative Costs	158,703	600,194	758,897	38,324	797,221	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	158,703	781,076	939,779	-1,762	938,017	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,468,700	896,923	2,365,623	-1,762	2,363,861	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1313 | Component CCN: 15-8550 | Period: From 01/01/2022 To 12/31/2022 | Worksheet M-1 | Date/Time Prepared: 5/26/2023 7:17 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	-79,967	965,994		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	-4,804	183,003		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	80,627		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	0		9.00
10.00	Subtotal (sum of lines 1 through 9)	-84,771	1,229,624		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	111,449		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	111,449		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-84,771	1,341,073		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	0		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	140,796		29.00
30.00	Administrative Costs	0	797,221		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	938,017		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-84,771	2,279,090		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1313 | Component CCN: 15-8549 | Period: From 01/01/2022 To 12/31/2022 | Worksheet M-1 | Date/Time Prepared: 5/26/2023 7:17 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	259,850	2,700	262,550	0	262,550	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	23,042	0	23,042	0	23,042	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	20,567	0	20,567	0	20,567	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	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	303,459	2,700	306,159	0	306,159	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	47,603	47,603	0	47,603	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	47,603	47,603	0	47,603	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	303,459	50,303	353,762	0	353,762	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	11,845	11,845	40,086	51,931	29.00
30.00	Administrative Costs	22,301	55,969	78,270	9,463	87,733	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	22,301	67,814	90,115	49,549	139,664	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	325,760	118,117	443,877	49,549	493,426	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS | Provider CCN: 15-1313 | Component CCN: 15-8549 | Period: From 01/01/2022 To 12/31/2022 | Worksheet M-1 | Date/Time Prepared: 5/26/2023 7:17 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	262,550		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	23,042		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	20,567		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	0		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	306,159		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	47,603		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	47,603		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	353,762		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	0		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	51,931		29.00
30.00	Administrative Costs	0	87,733		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	139,664		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	493,426		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1313 | Component CCN: 15-8547 | Period: From 01/01/2022 To 12/31/2022 | Worksheet M-1 | Date/Time Prepared: 5/26/2023 7:17 pm

RHC V | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	406,599	8,511	415,110	0	415,110	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	115,058	0	115,058	0	115,058	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	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	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	521,657	8,511	530,168	0	530,168	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	20,617	20,617	0	20,617	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	20,617	20,617	0	20,617	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	521,657	29,128	550,785	0	550,785	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	16,775	16,775	0	16,775	29.00
30.00	Administrative Costs	69,079	176,138	245,217	-11,868	233,349	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	69,079	192,913	261,992	-11,868	250,124	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	590,736	222,041	812,777	-11,868	800,909	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1313 | Component CCN: 15-8547 | Period: From 01/01/2022 To 12/31/2022 | Worksheet M-1 | Date/Time Prepared: 5/26/2023 7:17 pm

RHC V | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	-12,579	402,531		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	-8,606	106,452		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	0		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	0		9.00
10.00	Subtotal (sum of lines 1 through 9)	-21,185	508,983		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	20,617		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	20,617		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-21,185	529,600		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	0		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	16,775		29.00
30.00	Administrative Costs	0	233,349		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	250,124		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-21,185	779,724		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1313 | Component CCN: 15-8548 | Period: From 01/01/2022 To 12/31/2022 | Worksheet M-1 | Date/Time Prepared: 5/26/2023 7:17 pm

RHC VI | 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	721,170	0	721,170	0	721,170	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	203,431	0	203,431	0	203,431	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	39,597	0	39,597	0	39,597	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	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	964,198	0	964,198	0	964,198	10.00
11.00	Physician Services Under Agreement	0	646,014	646,014	0	646,014	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	646,014	646,014	0	646,014	14.00
15.00	Medical Supplies	0	167,706	167,706	0	167,706	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	167,706	167,706	0	167,706	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	964,198	813,720	1,777,918	0	1,777,918	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	36,258	36,258	0	36,258	29.00
30.00	Administrative Costs	161,679	357,350	519,029	-19,011	500,018	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	161,679	393,608	555,287	-19,011	536,276	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,125,877	1,207,328	2,333,205	-19,011	2,314,194	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1313 | Component CCN: 15-8548 | Period: From 01/01/2022 To 12/31/2022 | Worksheet M-1 | Date/Time Prepared: 5/26/2023 7:17 pm

RHC VI | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	-15,340	705,830		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	-16,068	187,363		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	39,597		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	0		9.00
10.00	Subtotal (sum of lines 1 through 9)	-31,408	932,790		10.00
11.00	Physician Services Under Agreement	0	646,014		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	646,014		14.00
15.00	Medical Supplies	0	167,706		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	167,706		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-31,408	1,746,510		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	0		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	36,258		29.00
30.00	Administrative Costs	0	500,018		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	536,276		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-31,408	2,282,786		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-1313 | Component CCN: 15-8551 | Period: From 01/01/2022 To 12/31/2022 | Worksheet M-2 | Date/Time Prepared: 5/26/2023 7:17 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	0.44	1,327	1	0		1.00
2.00	Physician Assistant	0.00	0	1	0		2.00
3.00	Nurse Practitioner	0.45	808	1	0		3.00
4.00	Subtotal (sum of lines 1 through 3)	0.89	2,135		0	2,135	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	0.89	2,135			2,135	8.00
9.00	Physician Services Under Agreements		3,909			3,909	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)					1,052,152	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					1,052,152	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					232,247	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					632,242	15.00
16.00	Total overhead (sum of lines 14 and 15)					864,489	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					864,489	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					864,489	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					1,916,641	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-1313 | Component CCN: 15-8552 | Period: From 01/01/2022 To 12/31/2022 | Worksheet M-2 | Date/Time Prepared: 5/26/2023 7:17 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	4.05	15,176	1	4		1.00
2.00	Physician Assistant	0.00	0	1	0		2.00
3.00	Nurse Practitioner	1.48	3,643	1	1		3.00
4.00	Subtotal (sum of lines 1 through 3)	5.53	18,819		5	18,819	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)	5.53	18,819			18,819	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)					3,110,805	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					3,110,805	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					853,034	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					1,832,486	15.00
16.00	Total overhead (sum of lines 14 and 15)					2,685,520	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					2,685,520	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					2,685,520	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					5,796,325	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-1313 Component CCN: 15-8550

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

Worksheet M-2 Date/Time Prepared: 5/26/2023 7:17 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	1.95	11,829	1	2		1.00
2.00	Physician Assistant	0.00	0	1	0		2.00
3.00	Nurse Practitioner	0.36	1,061	1	0		3.00
4.00	Subtotal (sum of lines 1 through 3)	2.31	12,890		2	12,890	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)	2.31	12,890			12,890	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)					1,341,073	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					1,341,073	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					938,017	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					664,046	15.00
16.00	Total overhead (sum of lines 14 and 15)					1,602,063	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					1,602,063	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					1,602,063	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					2,943,136	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-1313 Component CCN: 15-8549

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

Worksheet M-2 Date/Time Prepared: 5/26/2023 7:17 pm

RHC IV

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Cost: Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.43	2,612	1	0		1.00
2.00	Physician Assistant	0.00	0	1	0		2.00
3.00	Nurse Practitioner	0.36	916	1	0		3.00
4.00	Subtotal (sum of lines 1 through 3)	0.79	3,528		0	3,528	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	0.79	3,528			3,528	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)					353,762	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					353,762	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					139,664	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					145,474	15.00
16.00	Total overhead (sum of lines 14 and 15)					285,138	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					285,138	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					285,138	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					638,900	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-1313 | Component CCN: 15-8547 | Period: From 01/01/2022 To 12/31/2022 | Worksheet M-2 | Date/Time Prepared: 5/26/2023 7:17 pm

RHC V | 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	0.86	2,909	1	1		1.00
2.00	Physician Assistant	0.00	0	1	0		2.00
3.00	Nurse Practitioner	1.01	2,095	1	1		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.87	5,004		2	5,004	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)	1.87	5,004			5,004	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)					529,600	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					529,600	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					250,124	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					368,945	15.00
16.00	Total overhead (sum of lines 14 and 15)					619,069	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					619,069	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					619,069	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					1,148,669	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-1313 Component CCN: 15-8548

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

Worksheet M-2

Date/Time Prepared: 5/26/2023 7:17 pm

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	RHC VI Minimum Visits (col. 1 x col. 3)	Cost Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.56	4,690	1	1		1.00
2.00	Physician Assistant	0.00	0	1	0		2.00
3.00	Nurse Practitioner	1.60	6,126	1	2		3.00
4.00	Subtotal (sum of lines 1 through 3)	2.16	10,816		3	10,816	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)	2.16	10,816			10,816	8.00
9.00	Physician Services Under Agreements		6,864			6,864	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)					1,746,510	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					1,746,510	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					536,276	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					916,460	15.00
16.00	Total overhead (sum of lines 14 and 15)					1,452,736	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					1,452,736	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					1,452,736	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					3,199,246	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 15-1313 Component CCN: 15-8551	Period: From 01/01/2022 To 12/31/2022	Worksheet M-3 Date/Time Prepared: 5/26/2023 7:17 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)	1,916,641	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)	15,381	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)	1,901,260	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)	2,135	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)	3,909	5.00
6.00	Total adjusted visits (line 4 plus line 5)	6,044	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)	314.57	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	269.69	8.00
9.00	Rate for Program covered visits (see instructions)	0.00	269.69	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	1,581	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	426,380	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	426,380	16.00
16.01	Total program charges (see instructions)(from contractor's records)		263,217	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		3,369	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		5,457	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.)		309,582	16.04
16.05	Total program cost (see instructions)	0	315,039	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		33,946	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		45,133	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		315,039	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		5,472	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		320,511	22.00
23.00	Allowable bad debts (see instructions)		227	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		148	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)		320,659	26.00
26.01	Sequestration adjustment (see instructions)		4,041	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		305,734	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)		10,884	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: 15-1313 Component CCN: 15-8552	Period: From 01/01/2022 To 12/31/2022	Worksheet M-3 Date/Time Prepared: 5/26/2023 7:17 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)		5,796,325	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)		230,346	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)		5,565,979	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		18,819	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)		0	5.00
6.00	Total adjusted visits (line 4 plus line 5)		18,819	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		295.76	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	403.23	8.00
9.00	Rate for Program covered visits (see instructions)	0.00	295.76	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	514	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	152,021	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	152,021	16.00
16.01	Total program charges (see instructions)(from contractor's records)		83,124	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		6,305	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		11,531	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.)		103,680	16.04
16.05	Total program cost (see instructions)	0	115,211	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		10,890	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		13,186	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		115,211	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		3,006	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		118,217	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)		118,217	26.00
26.01	Sequestration adjustment (see instructions)		1,490	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		149,984	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)		-33,257	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: 15-1313 Component CCN: 15-8550	Period: From 01/01/2022 To 12/31/2022	Worksheet M-3 Date/Time Prepared: 5/26/2023 7:17 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)	2,943,136	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)	133,099	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)	2,810,037	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)	12,890	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)	0	5.00
6.00	Total adjusted visits (line 4 plus line 5)	12,890	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)	218.00	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	242.36	8.00
9.00	Rate for Program covered visits (see instructions)	0.00	218.00	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	2,174	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	473,932	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	473,932	16.00
16.01	Total program charges (see instructions)(from contractor's records)		336,122	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		4,783	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		6,744	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.)		335,713	16.04
16.05	Total program cost (see instructions)	0	342,457	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		47,547	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		56,735	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		342,457	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		47,752	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		390,209	22.00
23.00	Allowable bad debts (see instructions)		288	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		187	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)		390,396	26.00
26.01	Sequestration adjustment (see instructions)		4,919	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		366,044	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)		19,433	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: 15-1313 Component CCN: 15-8549	Period: From 01/01/2022 To 12/31/2022	Worksheet M-3 Date/Time Prepared: 5/26/2023 7:17 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)		638,900	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)		11,794	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)		627,106	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		3,528	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)		3,528	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		177.75	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	242.50	8.00
9.00	Rate for Program covered visits (see instructions)	0.00	177.75	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	651	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	115,715	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	115,715	16.00
16.01	Total program charges (see instructions)(from contractor's records)		100,797	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		0	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		0	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.)		77,743	16.04
16.05	Total program cost (see instructions)	0	77,743	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		18,536	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		16,452	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		77,743	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		4,699	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		82,442	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)		82,442	26.00
26.01	Sequestration adjustment (see instructions)		1,039	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		103,193	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)		-21,790	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: 15-1313 Component CCN: 15-8547	Period: From 01/01/2022 To 12/31/2022	Worksheet M-3 Date/Time Prepared: 5/26/2023 7:17 pm
	Title XVIII	RHC V	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)	1,148,669	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)	33,681	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)	1,114,988	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)	5,004	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)	5,004	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)	222.82	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	293.71	8.00
9.00	Rate for Program covered visits (see instructions)	0.00	222.82	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	771	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	171,794	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	171,794	16.00
16.01	Total program charges (see instructions)(from contractor's records)		120,849	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		11,141	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		15,838	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.)		110,139	16.04
16.05	Total program cost (see instructions)	0	125,977	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		18,282	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		18,285	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		125,977	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		11,350	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		137,327	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)		137,327	26.00
26.01	Sequestration adjustment (see instructions)		1,730	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		161,944	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)		-26,347	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: 15-1313 Component CCN: 15-8548	Period: From 01/01/2022 To 12/31/2022	Worksheet M-3 Date/Time Prepared: 5/26/2023 7:17 pm
	Title XVIII	RHC VI	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)		3,199,246	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)		125,350	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)		3,073,896	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		10,816	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)		6,864	5.00
6.00	Total adjusted visits (line 4 plus line 5)		17,680	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		173.86	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	212.16	8.00
9.00	Rate for Program covered visits (see instructions)	0.00	173.86	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	2,318	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	403,007	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)			15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	403,007	16.00
16.01	Total program charges (see instructions)(from contractor's records)		374,804	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		53,892	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		57,947	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.)		238,896	16.04
16.05	Total program cost (see instructions)	0	296,843	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		46,440	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		54,895	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		296,843	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		35,775	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		332,618	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)		332,618	26.00
26.01	Sequestration adjustment (see instructions)		4,191	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		349,514	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)		-21,087	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: 15-1313 | Component CCN: 15-8551 | Period: From 01/01/2022 To 12/31/2022 | Worksheet M-4 | Date/Time Prepared: 5/26/2023 7:17 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)	448,803	448,803	448,803	448,803	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000654	0.008342	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	294	3,744	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	856	3,549	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	1,150	7,293	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	1,052,152	1,052,152	1,052,152	1,052,152	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	864,489	864,489	864,489	864,489	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.001093	0.006932	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	945	5,993	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	2,095	13,286	0	0	10.00
11.00	Total number of injections/infusions (from your records)	8	102	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	261.88	130.25	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	1	40	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)	262	5,210	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)		15,381	15.00
16.00	Total Program cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount to Wkst. M-3, line 21)		5,472	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 15-1313 | Component CCN: 15-8552 | Period: From 01/01/2022 To 12/31/2022 | Worksheet M-4 | Date/Time Prepared: 5/26/2023 7:17 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)	2,682,602	2,682,602	2,682,602	2,682,602	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.006656	0.011088	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	17,855	29,745	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	49,304	26,719	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	67,159	56,464	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	3,110,805	3,110,805	3,110,805	3,110,805	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	2,685,520	2,685,520	2,685,520	2,685,520	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.021589	0.018151	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	57,978	48,745	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	125,137	105,209	0	0	10.00
11.00	Total number of injections/infusions (from your records)	461	768	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	271.45	136.99	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	3	16	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)	814	2,192	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)		230,346	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)		3,006	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 15-1313 | Component CCN: 15-8550 | Period: From 01/01/2022 To 12/31/2022 | Worksheet M-4 | Date/Time Prepared: 5/26/2023 7:17 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)	1,229,624	1,229,624	1,229,624	1,229,624	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.005215	0.017026	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	6,412	20,936	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	16,149	17,151	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	22,561	38,087	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	1,341,073	1,341,073	1,341,073	1,341,073	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	1,602,063	1,602,063	1,602,063	1,602,063	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.016823	0.028400	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	26,952	45,499	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	49,513	83,586	0	0	10.00
11.00	Total number of injections/infusions (from your records)	151	493	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	327.90	169.55	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	66	154	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)	21,641	26,111	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)		133,099	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)		47,752	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 15-1313 | Component CCN: 15-8549 | Period: From 01/01/2022 To 12/31/2022 | Worksheet M-4 | Date/Time Prepared: 5/26/2023 7:17 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)	306,159	306,159	306,159	306,159	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000763	0.008109	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	234	2,483	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	856	2,957	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	1,090	5,440	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	353,762	353,762	353,762	353,762	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	285,138	285,138	285,138	285,138	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.003081	0.015378	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	879	4,385	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	1,969	9,825	0	0	10.00
11.00	Total number of injections/infusions (from your records)	8	85	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	246.13	115.59	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	5	30	0	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	1,231	3,468	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)		11,794	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)		4,699	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 15-1313 | Component CCN: 15-8547 | Period: From 01/01/2022 To 12/31/2022 | Worksheet M-4 | Date/Time Prepared: 5/26/2023 7:17 pm

Title XVIII | RHC V | 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)	508,983	508,983	508,983	508,983	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.001077	0.009348	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	548	4,758	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	2,674	7,549	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	3,222	12,307	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	529,600	529,600	529,600	529,600	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	619,069	619,069	619,069	619,069	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.006084	0.023238	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	3,766	14,386	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	6,988	26,693	0	0	10.00
11.00	Total number of injections/infusions (from your records)	25	217	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	279.52	123.01	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	12	65	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)	3,354	7,996	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)		33,681	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)		11,350	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 15-1313 | Component CCN: 15-8548 | Period: From 01/01/2022 To 12/31/2022 | Worksheet M-4 | Date/Time Prepared: 5/26/2023 7:17 pm

Title XVIII | RHC VI | 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)	932,790	932,790	932,790	932,790	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.006751	0.020970	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	6,297	19,561	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	21,176	21,396	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	27,473	40,957	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	1,746,510	1,746,510	1,746,510	1,746,510	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	1,452,736	1,452,736	1,452,736	1,452,736	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.015730	0.023451	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	22,852	34,068	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	50,325	75,025	0	0	10.00
11.00	Total number of injections/infusions (from your records)	198	615	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	254.17	121.99	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	63	162	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)	16,013	19,762	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)		125,350	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)		35,775	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 15-1313 Component CCN: 15-8551	Period: From 01/01/2022 To 12/31/2022	Worksheet M-5 Date/Time Prepared: 5/26/2023 7:17 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		305,734	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)		305,734	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		10,884	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		316,618	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: 15-1313 Component CCN: 15-8552	Period: From 01/01/2022 To 12/31/2022	Worksheet M-5 Date/Time Prepared: 5/26/2023 7:17 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		149,984	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)		149,984	4.00
	TO BE COMPLETED BY CONTRACTOR			
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
	Program to Provider			
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
	Provider to Program			
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		0	6.01
6.02	SETTLEMENT TO PROGRAM		33,257	6.02
7.00	Total Medicare program liability (see instructions)		116,727	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: 15-1313 Component CCN: 15-8550	Period: From 01/01/2022 To 12/31/2022	Worksheet M-5 Date/Time Prepared: 5/26/2023 7:17 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		366,044	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)		366,044	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		19,433	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		385,477	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: 15-1313 Component CCN: 15-8549	Period: From 01/01/2022 To 12/31/2022	Worksheet M-5 Date/Time Prepared: 5/26/2023 7:17 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		103,193	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)		103,193	4.00
	TO BE COMPLETED BY CONTRACTOR			
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
	Program to Provider			
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
	Provider to Program			
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		0	6.01
6.02	SETTLEMENT TO PROGRAM		21,790	6.02
7.00	Total Medicare program liability (see instructions)		81,403	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: 15-1313 Component CCN: 15-8547	Period: From 01/01/2022 To 12/31/2022	Worksheet M-5 Date/Time Prepared: 5/26/2023 7:17 pm
		RHC V	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		161,944	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)		161,944	4.00
	TO BE COMPLETED BY CONTRACTOR			
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
	Program to Provider			
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
	Provider to Program			
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		0	6.01
6.02	SETTLEMENT TO PROGRAM		26,347	6.02
7.00	Total Medicare program liability (see instructions)		135,597	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: 15-1313 Component CCN: 15-8548	Period: From 01/01/2022 To 12/31/2022	Worksheet M-5 Date/Time Prepared: 5/26/2023 7:17 pm

		RHC VI	Cost	
		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		349,514	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)		349,514	4.00
	TO BE COMPLETED BY CONTRACTOR			
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
	Program to Provider			
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
	Provider to Program			
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		0	6.01
6.02	SETTLEMENT TO PROGRAM		21,087	6.02
7.00	Total Medicare program liability (see instructions)		328,427	7.00

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