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 03-31-2022

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 15-1319	Period: From 10/01/2021 To 09/30/2022	Worksheet S Parts I-III Date/Time Prepared: 2/23/2023 3:14 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 2/23/2023 Time: 3:14 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 or "L" for low.

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 DEACONESS GIBSON (15-1319) for the cost reporting period beginning 10/01/2021 and ending 09/30/2022 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	Lois Morgan		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	Lois Morgan			2
3	Signatory Title	CHIEF ADMIN OFFICER			3
4	Date	(Dated when report is electronica			4

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	25,051	97,054	0	47,134	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	374,931	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	RURAL HEALTH CLINIC I	0		-9,676		0	10.00
10.01	RURAL HEALTH CLINIC II	0		-8,490		0	10.01
200.00	Total	0	399,982	78,888	0	47,134	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 valid OMB control number for this information collection is 0938-0050. The time required to complete and review the information collection is estimated 673 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: 15-1319 | Period: From 10/01/2021 To 09/30/2022 | Worksheet S-2 Part I | Date/Time Prepared: 2/23/2023 3:14 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1800 SHERMAN DRIVE	PO Box:			1.00
2.00	City: PRINCETON	State: IN	Zip Code: 47670-	County: GIBSON	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	DEACONESS GIBSON	151319	99915	1	12/16/2003	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	GIBSON GENERAL SWING BED	15Z319	99915		12/16/2003	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	GIBSON HOME HEALTH	157445	99915		10/19/1995	N	P	N	12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC	GIBSON GENERAL FAMILY MEDICINE FORT	158524	99915		09/11/2017	N	O	O	15.00
15.01	Hospital-Based Health Clinic - RHC II	GIBSON GENERAL FAMILY MEDICINE- 510	158553	99915		05/29/2019	N	O	O	15.01
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	10/01/2021	09/30/2022	20.00
21.00	Type of Control (see instructions)	2		21.00

		1.00	2.00	3.00	
	Inpatient PPS Information				
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N	N		22.00
22.01	Did this hospital receive interim uncompensated care payments 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 final uncompensated care payments 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.	N	N	N	22.04
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	2	N		23.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1319 | Period: From 10/01/2021 To 09/30/2022 | Worksheet S-2 Part I | Date/Time Prepared: 2/23/2023 3:14 pm

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

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

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

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

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2.	N			56.00
57.00	If line 56 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.				57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.				58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1319 | Period: From 10/01/2021 To 09/30/2022 | Worksheet S-2 Part I Date/Time Prepared: 2/23/2023 3:14 pm

		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 adjustement? Enter "Y" for yes or "N" for no in column 2.	N			60.00

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1319 | Period: From 10/01/2021 To 09/30/2022 | Worksheet S-2 Part I Date/Time Prepared: 2/23/2023 3:14 pm

		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
		1.00	2.00	3.00	
	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.				
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	64.00

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00

		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
		1.00	2.00	3.00	
	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010				
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	66.00

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	67.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1319 | Period: From 10/01/2021 To 09/30/2022 | Worksheet S-2 Part I Date/Time Prepared: 2/23/2023 3:14 pm

		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

		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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1319 | Period: From 10/01/2021 To 09/30/2022 | Worksheet S-2 Part I Date/Time Prepared: 2/23/2023 3:14 pm

				V	XIX	
				1.00	2.00	
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.	Y	N	N	N	109.00
					1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration)for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.				N	110.00
				1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.			N		111.00
		1.00	2.00	3.00		
112.00	Did this hospital participate in the Pennsylvania Rural Health Model 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
	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:	27,845	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.		Y			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
	Transplant Center Information					
125.00	Does this facility operate a 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 center, 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 center, 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 center, enter the certification date in column 1 and termination date, if applicable, in column 2.					128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					129.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1319 | Period: From 10/01/2021 To 09/30/2022 | Worksheet S-2 Part I Date/Time Prepared: 2/23/2023 3:14 pm

		1.00	2.00	
130.00	If this is a Medicare certified pancreas transplant center, 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 center, 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 center, 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 an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	HB0778	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: DEACONESS HEALTH SYSTEM	Contractor's Name: WISCONSIN PHYSICIANS SERVICES	Contractor's Number: 08101	141.00
142.00	Street: 600 MARY STREET	PO Box:		142.00
143.00	City: EVANSVILLE	State: IN	Zip Code: 47710	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)	9.99	169.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1319	Period: From 10/01/2021 To 09/30/2022	Worksheet S-2 Part I Date/Time Prepared: 2/23/2023 3:14 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: 15-1319 | Period: From 10/01/2021 To 09/30/2022 | Worksheet S-2 Part II | Date/Time Prepared: 2/23/2023 3:14 pm

		Y/N	Date	
		1.00	2.00	
	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 is 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 co-payments 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	11/28/2022	Y	11/28/2022	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: 15-1319 | Period: From 10/01/2021 To 09/30/2022 | Worksheet S-2 Part II | Date/Time Prepared: 2/23/2023 3:14 pm

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

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

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

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	AUSTIN	FISHER	41.00
42.00	Enter the employer/company name of the cost report preparer.	BLUE & CO.		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-275-7438	AFISHER@BLUEANDCO.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-1319	Period: From 10/01/2021 To 09/30/2022	Worksheet S-2 Part II Date/Time Prepared: 2/23/2023 3:14 pm

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1319 | Period: From 10/01/2021 To 09/30/2022 | Worksheet S-3 Part I | Date/Time Prepared: 2/23/2023 3:14 pm

	Component	Worksheet A Line Number	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	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	25	9,125	16,224.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		25	9,125	16,224.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	0	0	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		25	9,125	16,224.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	88.00				0	26.00
26.01	RURAL HEALTH CLINIC II	88.01				0	26.01
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		25				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1319 | Period: From 10/01/2021 To 09/30/2022 | Worksheet S-3 Part I | Date/Time Prepared: 2/23/2023 3:14 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	
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)	256	18	676			1.00
2.00	HMO and other (see instructions)	214	72				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	1,062	0	1,062			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	1,047			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,318	18	2,785			7.00
8.00	INTENSIVE CARE UNIT	0	0	0			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	1,318	18	2,785	0.00	271.04	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	3,314	0	5,907	0.00	9.46	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	329	0	3,553	0.00	6.74	26.00
26.01	RURAL HEALTH CLINIC II	1,389	0	7,440	0.00	9.31	26.01
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	296.55	27.00
28.00	Observation Bed Days		147	944			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1319 | Period: From 10/01/2021 To 09/30/2022 | Worksheet S-3 Part I | Date/Time Prepared: 2/23/2023 3:14 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	
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	89	7	225	1.00
2.00	HMO and other (see instructions)			63	22		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	89	7	225	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0.00					26.00
26.01	RURAL HEALTH CLINIC II	0.00					26.01
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01

HOME HEALTH AGENCY STATISTICAL DATA | Provider CCN: 15-1319 | Component CCN: 15-7445 | Period: From 10/01/2021 To 09/30/2022 | Worksheet S-4 | Date/Time Prepared: 2/23/2023 3:14 pm

Home Health Agency I | PPS

						1.00	
0.00	County						0.00
		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
	HOME HEALTH AGENCY STATISTICAL DATA						
1.00	Home Health Aide Hours	0	0	0	0	0	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	111.00	0.00	0.00	0.00	2.00
				Number of Employees (Full Time Equivalent)			
		Enter the number of hours in your normal work week		Staff	Contract	Total	
		0		1.00	2.00	3.00	
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES						
3.00	Administrator and Assistant Administrator(s)		40.00	0.00	0.00	0.00	3.00
4.00	Director(s) and Assistant Director(s)			0.00	0.00	0.00	4.00
5.00	Other Administrative Personnel			0.00	0.00	0.00	5.00
6.00	Direct Nursing Service			3.08	0.00	3.08	6.00
7.00	Nursing Supervisor			0.00	0.00	0.00	7.00
8.00	Physical Therapy Service			2.49	0.00	2.49	8.00
9.00	Physical Therapy Supervisor			0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service			1.64	0.00	1.64	10.00
11.00	Occupational Therapy Supervisor			0.00	0.00	0.00	11.00
12.00	Speech Pathology Service			0.24	0.00	0.24	12.00
13.00	Speech Pathology Supervisor			0.00	0.00	0.00	13.00
14.00	Medical Social Service			0.00	0.00	0.00	14.00
15.00	Medical Social Service Supervisor			0.00	0.00	0.00	15.00
16.00	Home Health Aide			1.01	0.00	1.01	16.00
17.00	Home Health Aide Supervisor			0.00	0.00	0.00	17.00
18.00	Other (specify)			0.00	0.00	0.00	18.00
						CBSA Data	
						1.00	
	HOME HEALTH AGENCY CBSA CODES						
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.					1	19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).					99915	20.00
		Full Episodes					
		Without Outliers	With Outliers	LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		1.00	2.00	3.00	4.00	5.00	
	PPS ACTIVITY DATA						
21.00	Skilled Nursing Visits	901	316	29	14	1,260	21.00
22.00	Skilled Nursing Visit Charges	140,811	49,383	4,528	2,209	196,931	22.00
23.00	Physical Therapy Visits	615	451	6	14	1,086	23.00
24.00	Physical Therapy Visit Charges	105,003	77,133	1,026	2,501	185,663	24.00
25.00	Occupational Therapy Visits	338	386	1	7	732	25.00
26.00	Occupational Therapy Visit Charges	58,194	66,473	173	1,306	126,146	26.00
27.00	Speech Pathology Visits	41	84	0	0	125	27.00
28.00	Speech Pathology Visit Charges	7,627	15,587	0	0	23,214	28.00
29.00	Medical Social Service Visits	0	0	0	0	0	29.00
30.00	Medical Social Service Visit Charges	0	0	0	0	0	30.00
31.00	Home Health Aide Visits	52	58	0	1	111	31.00
32.00	Home Health Aide Visit Charges	3,673	4,115	0	71	7,859	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	1,947	1,295	36	36	3,314	33.00
34.00	Other Charges	0	0	0	0	0	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	315,308	212,691	5,727	6,087	539,813	35.00
36.00	Total Number of Episodes (standard/non outlier)	192		25	4	221	36.00
37.00	Total Number of Outlier Episodes		65		0	65	37.00
38.00	Total Non-Routine Medical Supply Charges	0	0	0	0	0	38.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-1319 | Component CCN: 15-8524 | Period: From 10/01/2021 To 09/30/2022 | Worksheet S-8 | Date/Time Prepared: 2/23/2023 3:14 pm

RHC I | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			7851 S. PROFESSIONAL DR.		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	FORT BRANCH		IN	47648	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 number	
		1.00	2.00	
14.00	RHC/FQHC name, CCN number			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		GIBSON				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: 15-1319
Component CCN: 15-8524

Period:
From 10/01/2021
To 09/30/2022

Worksheet S-8

Date/Time Prepared:
2/23/2023 3:14 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: 15-1319 | Component CCN: 15-8553 | Period: From 10/01/2021 To 09/30/2022 | Worksheet S-8 | Date/Time Prepared: 2/23/2023 3:14 pm

RHC II | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			510 N MAIN ST.		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	PRINCETON		IN	47670	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 number	
		1.00	2.00	
14.00	RHC/FQHC name, CCN number			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		GIBSON				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: 15-1319
Component CCN: 15-8553

Period:
From 10/01/2021
To 09/30/2022

Worksheet S-8

Date/Time Prepared:
2/23/2023 3:14 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 UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 15-1319	Period: From 10/01/2021 To 09/30/2022	Worksheet S-10 Date/Time Prepared: 2/23/2023 3:14 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)	0.457821	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	5,030,064	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	13,609,299	6.00
7.00	Medicaid cost (line 1 times line 6)	6,230,623	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	1,200,559	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	1,200,559	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)	1,268,402	87,649	1,356,051	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	580,701	87,649	668,350	21.00
22.00	Payments received from patients for amounts previously written off as charity care	29	589	618	22.00
23.00	Cost of charity care (line 21 minus line 22)	580,672	87,060	667,732	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)	1,466,929	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	179,402	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	276,003	27.01
28.00	Non-Medicare bad debt expense (see instructions)	1,190,926	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	641,832	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,309,564	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	2,510,123	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1319 | Period: From 10/01/2021 To 09/30/2022 | Worksheet A | Date/Time Prepared: 2/23/2023 3:14 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		2,028,687	2,028,687	407,059	2,435,746	1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	100,801	1,887,122	1,987,923	-6,772	1,981,151	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	958,484	5,276,274	6,234,758	130,677	6,365,435	5.00
7.00	00700	OPERATION OF PLANT	251,893	1,099,498	1,351,391	135,381	1,486,772	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	68,614	22,917	91,531	-3,873	87,658	8.00
9.00	00900	HOUSEKEEPING	295,729	141,706	437,435	-24,028	413,407	9.00
10.00	01000	DIETARY	342,273	269,737	612,010	-456,095	155,915	10.00
11.00	01100	CAFETERIA	0	0	0	441,191	441,191	11.00
13.00	01300	NURSING ADMINISTRATION	79,621	12,282	91,903	-1,254	90,649	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	164,475	123,330	287,805	-29,007	258,798	14.00
15.00	01500	PHARMACY	226,809	3,082,846	3,309,655	-8,960	3,300,695	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	90,355	42,847	133,202	-435	132,767	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,264,904	1,459,174	3,724,078	-197,893	3,526,185	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,304,041	899,706	2,203,747	-170,681	2,033,066	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,065,066	796,127	1,861,193	-38,856	1,822,337	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	158,788	158,788	-2,848	155,940	54.03
60.00	06000	LABORATORY	894,398	2,643,643	3,538,041	-200,794	3,337,247	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	47,976	47,976	-904	47,072	62.00
65.00	06500	RESPIRATORY THERAPY	539,793	581,737	1,121,530	-15,678	1,105,852	65.00
66.00	06600	PHYSICAL THERAPY	0	2,261,177	2,261,177	-53,217	2,207,960	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	613,852	613,852	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	101,399	101,399	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03480	INFUSION THERAPY	138,698	234,260	372,958	-48,565	324,393	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	418,630	420,250	838,880	-15,781	823,099	88.00
88.01	08801	RURAL HEALTH CLINIC II	769,891	337,303	1,107,194	-33,680	1,073,514	88.01
90.00	09000	CLINIC	87,347	75,262	162,609	-16,247	146,362	90.00
90.01	09001	DIABETES	0	520	520	0	520	90.01
90.02	09002	OP PSYCH	0	0	0	0	0	90.02
90.03	09003	PAIN MANAGEMENT	95,970	184,006	279,976	-1,116	278,860	90.03
91.00	09100	EMERGENCY	1,143,894	2,694,631	3,838,525	-44,639	3,793,886	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	520,991	385,262	906,253	-7,863	898,390	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		407,059	407,059	-407,059	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	11,822,677	27,574,127	39,396,804	43,314	39,440,118	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	MOB	1,369,925	1,263,617	2,633,542	-43,314	2,590,228	194.00
194.01	07951	FOUNDATION	0	0	0	0	0	194.01
194.02	07952	ASC	0	0	0	0	0	194.02
194.03	07953	SNF - PERRY CO.	0	0	0	0	0	194.03
194.04	07954	TELE BEHAVIORAL	0	0	0	0	0	194.04
200.00		TOTAL (SUM OF LINES 118 through 199)	13,192,602	28,837,744	42,030,346	0	42,030,346	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1319 | Period: From 10/01/2021 To 09/30/2022 | Worksheet A | Date/Time Prepared: 2/23/2023 3:14 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	-205,453	2,230,293		1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,386,814	3,367,965		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	538,784	6,904,219		5.00
7.00	00700	OPERATION OF PLANT	468,607	1,955,379		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	87,658		8.00
9.00	00900	HOUSEKEEPING	207,798	621,205		9.00
10.00	01000	DIETARY	106,799	262,714		10.00
11.00	01100	CAFETERIA	-116,747	324,444		11.00
13.00	01300	NURSING ADMINISTRATION	56,405	147,054		13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	258,798		14.00
15.00	01500	PHARMACY	312,747	3,613,442		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	24,255	157,022		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-37,430	3,488,755		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-624,272	1,408,794		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-428	1,821,909		54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	155,940		54.03
60.00	06000	LABORATORY	0	3,337,247		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	47,072		62.00
65.00	06500	RESPIRATORY THERAPY	-358,046	747,806		65.00
66.00	06600	PHYSICAL THERAPY	-300	2,207,660		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	613,852		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	101,399		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00	03480	INFUSION THERAPY	0	324,393		76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	-39,358	783,741		88.00
88.01	08801	RURAL HEALTH CLINIC II	-62,806	1,010,708		88.01
90.00	09000	CLINIC	0	146,362		90.00
90.01	09001	DIABETES	0	520		90.01
90.02	09002	OP PSYCH	0	0		90.02
90.03	09003	PAIN MANAGEMENT	0	278,860		90.03
91.00	09100	EMERGENCY	0	3,793,886		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	-887	897,503		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,656,482	41,096,600		118.00
		NONREIMBURSABLE COST CENTERS				
194.00	07950	MOB	-83,182	2,507,046		194.00
194.01	07951	FOUNDATION	0	0		194.01
194.02	07952	ASC	0	0		194.02
194.03	07953	SNF - PERRY CO.	0	0		194.03
194.04	07954	TELE BEHAVIORAL	0	0		194.04
200.00		TOTAL (SUM OF LINES 118 through 199)	1,573,300	43,603,646		200.00

RECLASSIFICATIONS | Provider CCN: 15-1319 | Period: From 10/01/2021 To 09/30/2022 | Worksheet A-6 | Date/Time Prepared: 2/23/2023 3:14 pm

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - CAFETERIA					
1.00	CAFETERIA	11.00	246,741	194,450		1.00
	0		246,741	194,450		
	B - MED SUPPLY CHG PTS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	613,852		1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	101,399		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
20.00		0.00	0	0		20.00
21.00		0.00	0	0		21.00
22.00		0.00	0	0		22.00
23.00		0.00	0	0		23.00
24.00		0.00	0	0		24.00
25.00		0.00	0	0		25.00
26.00		0.00	0	0		26.00
	0		0	715,251		
	C - BUSINESS HEALTH SER					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	14,194	6,639		1.00
	0		14,194	6,639		
	D - INTEREST					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	407,059		1.00
	0		0	407,059		
	E - QUALITY SERVICES					
1.00	ADMINISTRATIVE & GENERAL	5.00	96,089	54,285		1.00
	0		96,089	54,285		
	F - HEALTH INSURANCE					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	5,574		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
	0		0	5,574		
	G - MALPRACTICE RECLASS					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	20,874		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
	0		0	20,874		
	H - MOB COLLECTION EXPENSE					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	1,380		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
	0		0	1,380		
	I - UTILITIES RECLASS					
1.00	OPERATION OF PLANT	7.00	0	138,271		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
	0		0	138,271		
	J - MAINTENANCE RECLASS					
1.00	OPERATION OF PLANT	7.00	0	5,158		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
	0		0	5,158		

RECLASSIFICATIONS | Provider CCN: 15-1319 | Period: From 10/01/2021 To 09/30/2022 | Worksheet A-6 | Date/Time Prepared: 2/23/2023 3:14 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	K - PTO ACCRUAL RECLASS				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	2,437	0	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	7,185	0	2.00
3.00	LAUNDRY & LINEN SERVICE	8.00	146	0	3.00
4.00	ADULTS & PEDIATRICS	30.00	7,977	0	4.00
5.00	PAIN MANAGEMENT	90.03	470	0	5.00
	0		18,215	0	
500.00	Grand Total: Increases		375,239	1,548,941	500.00

RECLASSIFICATIONS | Provider CCN: 15-1319 | Period: From 10/01/2021 To 09/30/2022 | Worksheet A-6 | Date/Time Prepared: 2/23/2023 3:14 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - CAFETERIA						
1.00	DIETARY	10.00	246,741	194,450	0		1.00
	0		246,741	194,450			
	B - MED SUPPLY CHG PTS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33,179	0		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	8,350	0		2.00
3.00	OPERATION OF PLANT	7.00	0	8,048	0		3.00
4.00	LAUNDRY & LINEN SERVICE	8.00	0	3,873	0		4.00
5.00	HOUSEKEEPING	9.00	0	17,081	0		5.00
6.00	DIETARY	10.00	0	14,392	0		6.00
7.00	NURSING ADMINISTRATION	13.00	0	1,164	0		7.00
8.00	CENTRAL SERVICE & SUPPLY	14.00	0	28,945	0		8.00
9.00	PHARMACY	15.00	0	8,960	0		9.00
10.00	MEDICAL RECORDS & LIBRARY	16.00	0	435	0		10.00
11.00	ADULTS & PEDIATRICS	30.00	0	47,174	0		11.00
12.00	OPERATING ROOM	50.00	0	98,159	0		12.00
13.00	RADIOLOGY-DIAGNOSTIC	54.00	0	34,953	0		13.00
14.00	NUCLEAR MEDICINE-DIAGNOSTIC	54.03	0	2,848	0		14.00
15.00	LABORATORY	60.00	0	200,794	0		15.00
16.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	62.00	0	904	0		16.00
17.00	RESPIRATORY THERAPY	65.00	0	15,678	0		17.00
18.00	PHYSICAL THERAPY	66.00	0	36,939	0		18.00
19.00	INFUSION THERAPY	76.00	0	48,565	0		19.00
20.00	RURAL HEALTH CLINIC	88.00	0	12,410	0		20.00
21.00	RURAL HEALTH CLINIC II	88.01	0	12,296	0		21.00
22.00	CLINIC	90.00	0	16,247	0		22.00
23.00	PAIN MANAGEMENT	90.03	0	1,116	0		23.00
24.00	EMERGENCY	91.00	0	44,544	0		24.00
25.00	HOME HEALTH AGENCY	101.00	0	7,863	0		25.00
26.00	MOB	194.00	0	10,334	0		26.00
	0		0	715,251			
	C - BUSINESS HEALTH SER						
1.00	MOB	194.00	14,194	6,639	0		1.00
	0		14,194	6,639			
	D - INTEREST						
1.00	INTEREST EXPENSE	113.00	0	407,059	10		1.00
	0		0	407,059			
	E - QUALITY SERVICES						
1.00	ADULTS & PEDIATRICS	30.00	96,089	54,285	0		1.00
	0		96,089	54,285			
	F - HEALTH INSURANCE						
1.00	NURSING ADMINISTRATION	13.00	0	90	0		1.00
2.00	RURAL HEALTH CLINIC	88.00	0	418	0		2.00
3.00	RURAL HEALTH CLINIC II	88.01	0	1,798	0		3.00
4.00	MOB	194.00	0	3,268	0		4.00
	0		0	5,574			
	G - MALPRACTICE RECLASS						
1.00	RURAL HEALTH CLINIC	88.00	0	2,910	0		1.00
2.00	RURAL HEALTH CLINIC II	88.01	0	9,423	0		2.00
3.00	MOB	194.00	0	8,541	0		3.00
	0		0	20,874			
	H - MOB COLLECTION EXPENSE						
1.00	OPERATING ROOM	50.00	0	749	0		1.00
2.00	RURAL HEALTH CLINIC	88.00	0	43	0		2.00
3.00	RURAL HEALTH CLINIC II	88.01	0	250	0		3.00
4.00	MOB	194.00	0	338	0		4.00
	0		0	1,380			
	I - UTILITIES RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	33,601	0		1.00
2.00	HOUSEKEEPING	9.00	0	6,947	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	345	0		3.00
4.00	OPERATING ROOM	50.00	0	71,187	0		4.00
5.00	PHYSICAL THERAPY	66.00	0	16,278	0		5.00
6.00	RURAL HEALTH CLINIC II	88.01	0	9,913	0		6.00
	0		0	138,271			
	J - MAINTENANCE RECLASS						
1.00	DIETARY	10.00	0	512	0		1.00
2.00	CENTRAL SERVICE & SUPPLY	14.00	0	62	0		2.00
3.00	OPERATING ROOM	50.00	0	586	0		3.00
4.00	RADIOLOGY-DIAGNOSTIC	54.00	0	3,903	0		4.00
5.00	EMERGENCY	91.00	0	95	0		5.00
	0		0	5,158			

RECLASSIFICATIONS | Provider CCN: 15-1319 | Period: From 10/01/2021 To 09/30/2022 | Worksheet A-6 | Date/Time Prepared: 2/23/2023 3:14 pm

		Decreases				
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	K - PTO ACCRUAL RECLASS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	2,437	0	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	7,185	0	2.00
3.00	LAUNDRY & LINEN SERVICE	8.00	0	146	0	3.00
4.00	ADULTS & PEDIATRICS	30.00	0	7,977	0	4.00
5.00	PAIN MANAGEMENT	90.03	0	470	0	5.00
	0		0	18,215		
500.00	Grand Total: Decreases		357,024	1,567,156		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1319 | Period: From 10/01/2021 To 09/30/2022 | Worksheet A-7 Part I | Date/Time Prepared: 2/23/2023 3:14 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	421,244	0	0	0	0	1.00
2.00	Land Improvements	7,337,196	561,770	0	561,770	0	2.00
3.00	Buildings and Fixtures	1,700	1,096,893	0	1,096,893	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	8,369,933	875,474	0	875,474	0	5.00
6.00	Movable Equipment	0	0	0	0	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	16,130,073	2,534,137	0	2,534,137	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	16,130,073	2,534,137	0	2,534,137	0	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	421,244	0	1.00
2.00	Land Improvements	7,898,966	0	2.00
3.00	Buildings and Fixtures	1,098,593	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	9,245,407	0	5.00
6.00	Movable Equipment	0	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	18,664,210	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	18,664,210	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1319 | Period: From 10/01/2021 To 09/30/2022 | Worksheet A-7 Part II | Date/Time Prepared: 2/23/2023 3:14 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	1,790,441	0	0	238,246	0	1.00
3.00	Total (sum of lines 1-2)	1,790,441	0	0	238,246	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL			
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)		
		14.00	15.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2				
1.00	CAP REL COSTS-BLDG & FIXT	0	2,028,687		1.00
3.00	Total (sum of lines 1-2)	0	2,028,687		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1319 | Period: From 10/01/2021 To 09/30/2022 | Worksheet A-7 Part III | Date/Time Prepared: 2/23/2023 3:14 pm

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	18,664,210	0	18,664,210	1.000000	0	1.00
3.00	Total (sum of lines 1-2)	18,664,210	0	18,664,210	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1,790,441	201,606	1.00
3.00	Total (sum of lines 1-2)	0	0	0	1,790,441	201,606	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	238,246	0	0	2,230,293	1.00
3.00	Total (sum of lines 1-2)	0	238,246	0	0	2,230,293	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1319 | Period: From 10/01/2021 To 09/30/2022 | Worksheet A-8 | Date/Time Prepared: 2/23/2023 3:14 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	-205,453	CAP REL COSTS-BLDG & FIXT	1.00	10	1.00
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)	A	-239	ADMINISTRATIVE & GENERAL	5.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-6,371	OPERATION OF PLANT	7.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-125	OPERATION OF PLANT	7.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-980,493			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	3,764,192			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-116,747	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	-4,817	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		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	*** Cost Center Deleted ***	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1319 | Period: From 10/01/2021 To 09/30/2022 | Worksheet A-8 | Date/Time Prepared: 2/23/2023 3:14 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	MISC INCOME	B	-15,268	ADMINISTRATIVE & GENERAL	5.00	0	33.00
33.02	MISC INCOME	B	-10,283	RESPIRATORY THERAPY	65.00	0	33.02
33.03	MISC INCOME	B	-300	PHYSICAL THERAPY	66.00	0	33.03
33.04	PHYSICIAN RECRUITING	A	-487	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.04
33.06	HAF FEE	A	-2,291	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07	HAF FEE	A	-842,200	ADMINISTRATIVE & GENERAL	5.00	0	33.07
33.08	LOBBYING	A	-4,931	ADMINISTRATIVE & GENERAL	5.00	0	33.08
33.09	HHA MISC INCOME	B	-887	HOME HEALTH AGENCY	101.00	0	33.09
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		1,573,300				50.00

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 15-1319 | Period: From 10/01/2021 To 09/30/2022 | Worksheet A-8-1 | Date/Time Prepared: 2/23/2023 3:14 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	EMPLOYEE BENEFITS	1,467,365	80,064	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	ADMIN & GENERAL	2,622,034	1,384,346	2.00
3.00	7.00	OPERATION OF PLANT	MAINTENANCE	475,103	0	3.00
3.01	9.00	HOUSEKEEPING	HOUSEKEEPING	207,798	0	3.01
3.02	10.00	DIETARY	DIETARY	106,799	0	3.02
4.00	13.00	NURSING ADMINISTRATION	NURSING ADMIN	56,405	0	4.00
4.01	15.00	PHARMACY	PHARMACY	312,747	0	4.01
4.02	16.00	MEDICAL RECORDS & LIBRARY	MEDICAL RECORDS	40,223	11,151	4.02
4.03	5.00	ADMINISTRATIVE & GENERAL	ADMINISTRATIVE & GENERAL	262,942	0	4.03
4.04	30.00	ADULTS & PEDIATRICS	A&P	0	37,430	4.04
4.05	88.00	RURAL HEALTH CLINIC	MAIN STREET	0	39,358	4.05
4.06	88.01	RURAL HEALTH CLINIC II	FAMILY MEDICAL CLINIC	0	62,806	4.06
4.07	194.00	MOB	FORT BRANCH	0	83,182	4.07
4.08	5.00	ADMINISTRATIVE & GENERAL	ADMIN & GENERAL	1,425,446	1,514,333	4.08
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			6,976,862	3,212,670	5.00

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

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

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

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

6.00	G		0.00	DEACONESS HOSP	100.00	6.00
7.00	G		0.00	HRS	100.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:	HOME OFFICE				100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 15-1319	Period: From 10/01/2021 To 09/30/2022	Worksheet A-8-1 Date/Time Prepared: 2/23/2023 3:14 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	1,387,301	0		1.00
2.00	1,237,688	0		2.00
3.00	475,103	0		3.00
3.01	207,798	0		3.01
3.02	106,799	0		3.02
4.00	56,405	0		4.00
4.01	312,747	0		4.01
4.02	29,072	0		4.02
4.03	262,942	0		4.03
4.04	-37,430	0		4.04
4.05	-39,358	0		4.05
4.06	-62,806	0		4.06
4.07	-83,182	0		4.07
4.08	-88,887	0		4.08
5.00	3,764,192			5.00

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

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

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

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

6.00	HOME OFFICE		6.00
7.00	PFS		7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-1319 | Period: From 10/01/2021 To 09/30/2022 | Worksheet A-8-2 | Date/Time Prepared: 2/23/2023 3:14 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	8,030	8,030	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	359,779	0	359,779	0	0	2.00
3.00	50.00	OPERATING ROOM	624,272	624,272	0	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	428	428	0	0	0	4.00
5.00	60.00	LABORATORY	40,000	0	40,000	0	0	5.00
6.00	65.00	RESPIRATORY THERAPY	347,763	347,763	0	0	0	6.00
7.00	91.00	EMERGENCY	1,142,592	0	1,142,592	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			2,522,864	980,493	1,542,371		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	50.00	OPERATING ROOM	0	0	0	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	4.00
5.00	60.00	LABORATORY	0	0	0	0	0	5.00
6.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	6.00
7.00	91.00	EMERGENCY	0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	8,030		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	0		2.00
3.00	50.00	OPERATING ROOM	0	0	0	624,272		3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	428		4.00
5.00	60.00	LABORATORY	0	0	0	0		5.00
6.00	65.00	RESPIRATORY THERAPY	0	0	0	347,763		6.00
7.00	91.00	EMERGENCY	0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	980,493		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 15-1319	Period: From 10/01/2021 To 09/30/2022	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 2/23/2023 3:14 pm

Physical Therapy — Cost

						1.00	
	PART I - GENERAL INFORMATION						
1.00	Total number of weeks worked (excluding aides) (see instructions)					52	1.00
2.00	Line 1 multiplied by 15 hours per week					780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					365	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					3.25	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	15,202.03	10,526.14	8,799.91	0.00	9.00
10.00	AHSEA (see instructions)	92.74	92.74	69.56	34.78	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	46.37	46.37	34.78			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION						
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					1,409,836	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)					732,198	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					2,142,034	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					306,061	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					2,448,095	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.						
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					0	22.00
23.00	Total salary equivalency (see instructions)					2,448,095	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE						
	Standard Travel Allowance						
24.00	Therapists (line 3 times column 2, line 11)					16,925	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					16,925	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					1,186	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					18,111	28.00
	Optional Travel Allowance and Optional Travel Expense						
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					0	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE						
	Standard Travel Expense						
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
	Optional Travel Allowance and Optional Travel Expense						
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.						
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 15-1319 | Period: From 10/01/2021 To 09/30/2022 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 2/23/2023 3:14 pm

Physical Therapy — Cost

						1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	92.74	69.56	34.78	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00		
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT			
57.00	Salary equivalency amount (from line 23)	2,448,095		57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	0		58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0		59.00
60.00	Overtime allowance (from column 5, line 56)	0		60.00
61.00	Equipment cost (see instructions)	0		61.00
62.00	Supplies (see instructions)	0		62.00
63.00	Total allowance (sum of lines 57-62)	2,448,095		63.00
64.00	Total cost of outside supplier services (from your records)	2,039,454		64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0		65.00
	LINE 33 CALCULATION			
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	16,925		100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	1,186		100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	18,111		100.02
	LINE 34 CALCULATION			
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	1,186		101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0		101.01
101.02	Line 34 = sum of lines 27 and 31	1,186		101.02
	LINE 35 CALCULATION			
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0		102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0		102.01
102.02	Line 35 = sum of lines 31 and 32	0		102.02

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1319 | Period: From 10/01/2021 To 09/30/2022 | Worksheet B Part I | Date/Time Prepared: 2/23/2023 3:14 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
			0	1.00	4.00	4A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	2,230,293	2,230,293				1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,367,965	19,240	3,387,205			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	6,904,219	113,037	274,673	7,291,929	7,291,929	5.00
7.00	00700	OPERATION OF PLANT	1,955,379	608,497	65,164	2,629,040	527,951	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	87,658	39,598	17,788	145,044	29,127	8.00
9.00	00900	HOUSEKEEPING	621,205	22,350	76,504	720,059	144,599	9.00
10.00	01000	DIETARY	262,714	28,375	24,714	315,803	63,418	10.00
11.00	01100	CAFETERIA	324,444	73,293	63,831	461,568	92,690	11.00
13.00	01300	NURSING ADMINISTRATION	147,054	6,705	20,598	174,357	35,014	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	258,798	87,189	42,549	388,536	78,024	14.00
15.00	01500	PHARMACY	3,613,442	32,602	58,675	3,704,719	743,963	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	157,022	32,383	23,374	212,779	42,729	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,488,755	269,655	563,125	4,321,535	867,820	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,408,794	123,993	337,350	1,870,137	375,552	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,821,909	84,929	275,528	2,182,366	438,252	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	155,940	10,203	0	166,143	33,364	54.03
60.00	06000	LABORATORY	3,337,247	37,169	231,377	3,605,793	724,097	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	47,072	0	0	47,072	9,453	62.00
65.00	06500	RESPIRATORY THERAPY	747,806	39,161	139,642	926,609	186,077	65.00
66.00	06600	PHYSICAL THERAPY	2,207,660	97,902	0	2,305,562	462,991	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	613,852	0	0	613,852	123,271	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	101,399	0	0	101,399	20,362	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03480	INFUSION THERAPY	324,393	25,921	35,881	386,195	77,554	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	783,741	0	108,298	892,039	179,135	88.00
88.01	08801	RURAL HEALTH CLINIC II	1,010,708	34,982	199,168	1,244,858	249,986	88.01
90.00	09000	CLINIC	146,362	0	22,596	168,958	33,929	90.00
90.01	09001	DIABETES	520	0	0	520	104	90.01
90.02	09002	OP PSYCH	0	0	0	0	0	90.02
90.03	09003	PAIN MANAGEMENT	278,860	38,262	24,949	342,071	68,693	90.03
91.00	09100	EMERGENCY	3,793,886	189,050	295,921	4,278,857	859,259	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	897,503	12,268	134,778	1,044,549	209,761	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	41,096,600	2,026,764	3,036,483	40,542,349	6,677,175	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	MOB	2,507,046	171,729	350,722	3,029,497	608,368	194.00
194.01	07951	FOUNDATION	0	31,800	0	31,800	6,386	194.01
194.02	07952	ASC	0	0	0	0	0	194.02
194.03	07953	SNF - PERRY CO.	0	0	0	0	0	194.03
194.04	07954	TELE BEHAVIORAL	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	43,603,646	2,230,293	3,387,205	43,603,646	7,291,929	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1319 | Period: From 10/01/2021 To 09/30/2022 | Worksheet B Part I | Date/Time Prepared: 2/23/2023 3:14 pm

		Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	3,156,991					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	83,927	258,098				8.00
9.00	00900	HOUSEKEEPING	47,370	0	912,028			9.00
10.00	01000	DIETARY	60,139	0	18,128	457,488		10.00
11.00	01100	CAFETERIA	155,342	0	46,824	0	756,424	11.00
13.00	01300	NURSING ADMINISTRATION	14,211	0	4,284	0	6,093	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	184,794	0	55,702	0	12,587	14.00
15.00	01500	PHARMACY	69,098	0	20,828	0	17,357	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	68,635	0	20,688	0	6,915	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	571,527	258,098	172,274	457,488	166,580	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	262,799	0	79,215	0	99,794	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	180,005	0	54,259	0	81,506	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	21,625	0	6,518	0	0	54.03
60.00	06000	LABORATORY	78,778	0	23,746	0	68,446	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	83,000	0	25,019	0	41,309	65.00
66.00	06600	PHYSICAL THERAPY	207,500	0	62,546	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03480	INFUSION THERAPY	54,939	0	16,560	0	10,614	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	74,144	0	22,349	0	0	88.01
90.00	09000	CLINIC	0	0	0	0	6,684	90.00
90.01	09001	DIABETES	0	0	0	0	0	90.01
90.02	09002	OP PSYCH	0	0	0	0	0	90.02
90.03	09003	PAIN MANAGEMENT	81,095	0	24,444	0	7,380	90.03
91.00	09100	EMERGENCY	400,687	0	120,778	0	87,539	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	26,002	0	7,838	0	39,870	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,725,617	258,098	782,000	457,488	652,674	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	MOB	363,975	0	109,712	0	103,750	194.00
194.01	07951	FOUNDATION	67,399	0	20,316	0	0	194.01
194.02	07952	ASC	0	0	0	0	0	194.02
194.03	07953	SNF - PERRY CO.	0	0	0	0	0	194.03
194.04	07954	TELE BEHAVIORAL	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	3,156,991	258,098	912,028	457,488	756,424	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1319 | Period: From 10/01/2021 To 09/30/2022 | Worksheet B Part I | Date/Time Prepared: 2/23/2023 3:14 pm

		Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICE & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	
			13.00	14.00	15.00	16.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	233,959					13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	719,643				14.00
15.00	01500	PHARMACY	5,547	7,141	4,568,653			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,816	250	0	354,812		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	58,655	65,484	0	15,128	6,954,589	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	40,349	143,705	0	34,258	2,905,809	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	31,006	20,654	0	94,496	3,082,544	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	1,723	0	3,246	232,619	54.03
60.00	06000	LABORATORY	26,484	122,625	0	56,478	4,706,447	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	520	0	651	57,696	62.00
65.00	06500	RESPIRATORY THERAPY	15,884	9,842	0	21,139	1,308,879	65.00
66.00	06600	PHYSICAL THERAPY	0	21,891	0	38,983	3,099,473	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	120,507	0	0	857,630	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	19,906	0	0	141,667	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	4,568,653	47,788	4,616,441	73.00
76.00	03480	INFUSION THERAPY	4,337	27,991	0	2,458	580,648	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	7,223	0	0	1,078,397	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	7,308	0	0	1,598,645	88.01
90.00	09000	CLINIC	2,482	9,408	0	966	222,427	90.00
90.01	09001	DIABETES	0	0	0	71	695	90.01
90.02	09002	OP PSYCH	0	0	0	0	0	90.02
90.03	09003	PAIN MANAGEMENT	0	650	0	850	525,183	90.03
91.00	09100	EMERGENCY	31,091	119,571	0	38,300	5,936,082	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	15,308	4,634	0	0	1,347,962	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	233,959	711,033	4,568,653	354,812	39,253,833	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	MOB	0	8,610	0	0	4,223,912	194.00
194.01	07951	FOUNDATION	0	0	0	0	125,901	194.01
194.02	07952	ASC	0	0	0	0	0	194.02
194.03	07953	SNF - PERRY CO.	0	0	0	0	0	194.03
194.04	07954	TELE BEHAVIORAL	0	0	0	0	0	194.04
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)	233,959	719,643	4,568,653	354,812	43,603,646	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1319 | Period: From 10/01/2021 To 09/30/2022 | Worksheet B Part I | Date/Time Prepared: 2/23/2023 3:14 pm

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
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 SERVICE & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	6,954,589		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	2,905,809		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,082,544		54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	232,619		54.03
60.00	06000	LABORATORY	0	4,706,447		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	57,696		62.00
65.00	06500	RESPIRATORY THERAPY	0	1,308,879		65.00
66.00	06600	PHYSICAL THERAPY	0	3,099,473		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	857,630		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	141,667		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	4,616,441		73.00
76.00	03480	INFUSION THERAPY	0	580,648		76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	1,078,397		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	1,598,645		88.01
90.00	09000	CLINIC	0	222,427		90.00
90.01	09001	DIABETES	0	695		90.01
90.02	09002	OP PSYCH	0	0		90.02
90.03	09003	PAIN MANAGEMENT	0	525,183		90.03
91.00	09100	EMERGENCY	0	5,936,082		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0			92.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	1,347,962		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	39,253,833		118.00
		NONREIMBURSABLE COST CENTERS				
194.00	07950	MOB	0	4,223,912		194.00
194.01	07951	FOUNDATION	0	125,901		194.01
194.02	07952	ASC	0	0		194.02
194.03	07953	SNF - PERRY CO.	0	0		194.03
194.04	07954	TELE BEHAVIORAL	0	0		194.04
200.00		Cross Foot Adjustments	0	0		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	0	43,603,646		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1319 | Period: From 10/01/2021 To 09/30/2022 | Worksheet B Part II | Date/Time Prepared: 2/23/2023 3:14 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	
			0	1.00	2A	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	19,240	19,240	19,240		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	113,037	113,037	1,560	114,597	5.00
7.00	00700	OPERATION OF PLANT	0	608,497	608,497	370	8,297	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	39,598	39,598	101	458	8.00
9.00	00900	HOUSEKEEPING	0	22,350	22,350	434	2,273	9.00
10.00	01000	DIETARY	0	28,375	28,375	140	997	10.00
11.00	01100	CAFETERIA	0	73,293	73,293	362	1,457	11.00
13.00	01300	NURSING ADMINISTRATION	0	6,705	6,705	117	550	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	87,189	87,189	242	1,226	14.00
15.00	01500	PHARMACY	0	32,602	32,602	333	11,692	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	32,383	32,383	133	672	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	269,655	269,655	3,203	13,635	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	123,993	123,993	1,916	5,902	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	84,929	84,929	1,565	6,888	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	10,203	10,203	0	524	54.03
60.00	06000	LABORATORY	0	37,169	37,169	1,314	11,380	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	149	62.00
65.00	06500	RESPIRATORY THERAPY	0	39,161	39,161	793	2,924	65.00
66.00	06600	PHYSICAL THERAPY	0	97,902	97,902	0	7,276	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	1,937	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	320	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03480	INFUSION THERAPY	0	25,921	25,921	204	1,219	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	615	2,815	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	34,982	34,982	1,131	3,929	88.01
90.00	09000	CLINIC	0	0	0	128	533	90.00
90.01	09001	DIABETES	0	0	0	0	2	90.01
90.02	09002	OP PSYCH	0	0	0	0	0	90.02
90.03	09003	PAIN MANAGEMENT	0	38,262	38,262	142	1,080	90.03
91.00	09100	EMERGENCY	0	189,050	189,050	1,680	13,504	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	12,268	12,268	765	3,297	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	2,026,764	2,026,764	17,248	104,936	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	MOB	0	171,729	171,729	1,992	9,561	194.00
194.01	07951	FOUNDATION	0	31,800	31,800	0	100	194.01
194.02	07952	ASC	0	0	0	0	0	194.02
194.03	07953	SNF - PERRY CO.	0	0	0	0	0	194.03
194.04	07954	TELE BEHAVIORAL	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments			0			200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	2,230,293	2,230,293	19,240	114,597	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1319 | Period: From 10/01/2021 To 09/30/2022 | Worksheet B Part II | Date/Time Prepared: 2/23/2023 3:14 pm

		Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	617,164					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	16,407	56,564				8.00
9.00	00900	HOUSEKEEPING	9,260	0	34,317			9.00
10.00	01000	DIETARY	11,757	0	682	41,951		10.00
11.00	01100	CAFETERIA	30,368	0	1,762	0	107,242	11.00
13.00	01300	NURSING ADMINISTRATION	2,778	0	161	0	864	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	36,126	0	2,096	0	1,785	14.00
15.00	01500	PHARMACY	13,508	0	784	0	2,461	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	13,417	0	778	0	980	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	111,729	56,564	6,483	41,951	23,613	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	51,375	0	2,981	0	14,149	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	35,189	0	2,042	0	11,556	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	4,228	0	245	0	0	54.03
60.00	06000	LABORATORY	15,400	0	893	0	9,704	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	16,226	0	941	0	5,857	65.00
66.00	06600	PHYSICAL THERAPY	40,564	0	2,353	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03480	INFUSION THERAPY	10,740	0	623	0	1,505	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	14,495	0	841	0	0	88.01
90.00	09000	CLINIC	0	0	0	0	948	90.00
90.01	09001	DIABETES	0	0	0	0	0	90.01
90.02	09002	OP PSYCH	0	0	0	0	0	90.02
90.03	09003	PAIN MANAGEMENT	15,853	0	920	0	1,046	90.03
91.00	09100	EMERGENCY	78,331	0	4,545	0	12,411	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	5,083	0	295	0	5,653	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	532,834	56,564	29,425	41,951	92,532	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	MOB	71,154	0	4,128	0	14,710	194.00
194.01	07951	FOUNDATION	13,176	0	764	0	0	194.01
194.02	07952	ASC	0	0	0	0	0	194.02
194.03	07953	SNF - PERRY CO.	0	0	0	0	0	194.03
194.04	07954	TELE BEHAVIORAL	0	0	0	0	0	194.04
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)	617,164	56,564	34,317	41,951	107,242	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1319 | Period: From 10/01/2021 To 09/30/2022 | Worksheet B Part II Date/Time Prepared: 2/23/2023 3:14 pm

		Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICE & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	
			13.00	14.00	15.00	16.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	11,175					13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	128,664				14.00
15.00	01500	PHARMACY	265	1,277	62,922			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	135	45	0	48,543		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,800	11,708	0	2,070	543,411	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,928	25,692	0	4,686	232,622	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,481	3,693	0	12,933	160,276	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	308	0	444	15,952	54.03
60.00	06000	LABORATORY	1,265	21,924	0	7,726	106,775	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	93	0	89	331	62.00
65.00	06500	RESPIRATORY THERAPY	759	1,760	0	2,892	71,313	65.00
66.00	06600	PHYSICAL THERAPY	0	3,914	0	5,333	157,342	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	21,545	0	0	23,482	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	3,559	0	0	3,879	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	62,922	6,537	69,459	73.00
76.00	03480	INFUSION THERAPY	207	5,004	0	336	45,759	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	1,291	0	0	4,721	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	1,307	0	0	56,685	88.01
90.00	09000	CLINIC	119	1,682	0	132	3,542	90.00
90.01	09001	DIABETES	0	0	0	10	12	90.01
90.02	09002	OP PSYCH	0	0	0	0	0	90.02
90.03	09003	PAIN MANAGEMENT	0	116	0	116	57,535	90.03
91.00	09100	EMERGENCY	1,485	21,378	0	5,239	327,623	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	731	829	0	0	28,921	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	11,175	127,125	62,922	48,543	1,909,640	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	MOB	0	1,539	0	0	274,813	194.00
194.01	07951	FOUNDATION	0	0	0	0	45,840	194.01
194.02	07952	ASC	0	0	0	0	0	194.02
194.03	07953	SNF - PERRY CO.	0	0	0	0	0	194.03
194.04	07954	TELE BEHAVIORAL	0	0	0	0	0	194.04
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)	11,175	128,664	62,922	48,543	2,230,293	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1319 | Period: From 10/01/2021 To 09/30/2022 | Worksheet B Part II | Date/Time Prepared: 2/23/2023 3:14 pm

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
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 SERVICE & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	543,411		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	232,622		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	160,276		54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	15,952		54.03
60.00	06000	LABORATORY	0	106,775		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	331		62.00
65.00	06500	RESPIRATORY THERAPY	0	71,313		65.00
66.00	06600	PHYSICAL THERAPY	0	157,342		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	23,482		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	3,879		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	69,459		73.00
76.00	03480	INFUSION THERAPY	0	45,759		76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	4,721		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	56,685		88.01
90.00	09000	CLINIC	0	3,542		90.00
90.01	09001	DIABETES	0	12		90.01
90.02	09002	OP PSYCH	0	0		90.02
90.03	09003	PAIN MANAGEMENT	0	57,535		90.03
91.00	09100	EMERGENCY	0	327,623		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0			92.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	28,921		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	1,909,640		118.00
		NONREIMBURSABLE COST CENTERS				
194.00	07950	MOB	0	274,813		194.00
194.01	07951	FOUNDATION	0	45,840		194.01
194.02	07952	ASC	0	0		194.02
194.03	07953	SNF - PERRY CO.	0	0		194.03
194.04	07954	TELE BEHAVIORAL	0	0		194.04
200.00		Cross Foot Adjustments	0	0		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	0	2,230,293		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1319 | Period: From 10/01/2021 To 09/30/2022 | Worksheet B-1 | Date/Time Prepared: 2/23/2023 3:14 pm

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
			1.00	4.00	5A	5.00	7.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	91,807					1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	792	13,093,385				4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,653	1,061,758	-7,291,929	36,311,717		5.00
7.00	00700	OPERATION OF PLANT	25,048	251,893	0	2,629,040	61,314	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,630	68,760	0	145,044	1,630	8.00
9.00	00900	HOUSEKEEPING	920	295,729	0	720,059	920	9.00
10.00	01000	DIETARY	1,168	95,532	0	315,803	1,168	10.00
11.00	01100	CAFETERIA	3,017	246,741	0	461,568	3,017	11.00
13.00	01300	NURSING ADMINISTRATION	276	79,621	0	174,357	276	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	3,589	164,475	0	388,536	3,589	14.00
15.00	01500	PHARMACY	1,342	226,809	0	3,704,719	1,342	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,333	90,355	0	212,779	1,333	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,100	2,176,792	0	4,321,535	11,100	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,104	1,304,041	0	1,870,137	5,104	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,496	1,065,066	0	2,182,366	3,496	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	420	0	0	166,143	420	54.03
60.00	06000	LABORATORY	1,530	894,398	0	3,605,793	1,530	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	47,072	0	62.00
65.00	06500	RESPIRATORY THERAPY	1,612	539,793	0	926,609	1,612	65.00
66.00	06600	PHYSICAL THERAPY	4,030	0	0	2,305,562	4,030	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	613,852	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	101,399	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03480	INFUSION THERAPY	1,067	138,698	0	386,195	1,067	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	418,630	0	892,039	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	1,440	769,891	0	1,244,858	1,440	88.01
90.00	09000	CLINIC	0	87,347	0	168,958	0	90.00
90.01	09001	DIABETES	0	0	0	520	0	90.01
90.02	09002	OP PSYCH	0	0	0	0	0	90.02
90.03	09003	PAIN MANAGEMENT	1,575	96,440	0	342,071	1,575	90.03
91.00	09100	EMERGENCY	7,782	1,143,894	0	4,278,857	7,782	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	505	520,991	0	1,044,549	505	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	83,429	11,737,654	-7,291,929	33,250,420	52,936	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	MOB	7,069	1,355,731	0	3,029,497	7,069	194.00
194.01	07951	FOUNDATION	1,309	0	0	31,800	1,309	194.01
194.02	07952	ASC	0	0	0	0	0	194.02
194.03	07953	SNF - PERRY CO.	0	0	0	0	0	194.03
194.04	07954	TELE BEHAVIORAL	0	0	0	0	0	194.04
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)	2,230,293	3,387,205		7,291,929	3,156,991	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	24.293278	0.258696		0.200815	51.488910	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		19,240		114,597	617,164	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.001469		0.003156	10.065629	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: 15-1319 | Period: From 10/01/2021 To 09/30/2022 | Worksheet B-1 | Date/Time Prepared: 2/23/2023 3:14 pm

		Cost Center Description	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	CAFETERIA (GROSS SALARIES)	NURSING ADMINISTRATION (NURSE SALARIES)	
			8.00	9.00	10.00	11.00	13.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,785					8.00
9.00	00900	HOUSEKEEPING	0	58,764				9.00
10.00	01000	DIETARY	0	1,168	2,785			10.00
11.00	01100	CAFETERIA	0	3,017	0	9,884,451		11.00
13.00	01300	NURSING ADMINISTRATION	0	276	0	79,621	7,201,866	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	3,589	0	164,475	0	14.00
15.00	01500	PHARMACY	0	1,342	0	226,809	170,746	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,333	0	90,355	86,691	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,785	11,100	2,785	2,176,792	1,805,556	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	5,104	0	1,304,041	1,242,031	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,496	0	1,065,066	954,436	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	420	0	0	0	54.03
60.00	06000	LABORATORY	0	1,530	0	894,398	815,236	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	1,612	0	539,793	488,961	65.00
66.00	06600	PHYSICAL THERAPY	0	4,030	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03480	INFUSION THERAPY	0	1,067	0	138,698	133,501	76.00
		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	1,440	0	0	0	88.01
90.00	09000	CLINIC	0	0	0	87,347	76,409	90.00
90.01	09001	DIABETES	0	0	0	0	0	90.01
90.02	09002	OP PSYCH	0	0	0	0	0	90.02
90.03	09003	PAIN MANAGEMENT	0	1,575	0	96,440	0	90.03
91.00	09100	EMERGENCY	0	7,782	0	1,143,894	957,068	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	505	0	520,991	471,231	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,785	50,386	2,785	8,528,720	7,201,866	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	MOB	0	7,069	0	1,355,731	0	194.00
194.01	07951	FOUNDATION	0	1,309	0	0	0	194.01
194.02	07952	ASC	0	0	0	0	0	194.02
194.03	07953	SNF - PERRY CO.	0	0	0	0	0	194.03
194.04	07954	TELE BEHAVIORAL	0	0	0	0	0	194.04
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)	258,098	912,028	457,488	756,424	233,959	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	92.674327	15.520182	164.268582	0.076527	0.032486	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	56,564	34,317	41,951	107,242	11,175	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	20.310233	0.583980	15.063196	0.010850	0.001552	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: 15-1319 | Period: From 10/01/2021 To 09/30/2022 | Worksheet B-1 | Date/Time Prepared: 2/23/2023 3:14 pm

		Cost Center Description	CENTRAL SERVICE & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)		
			14.00	15.00	16.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	3,665,817				14.00
15.00	01500	PHARMACY	36,377	100			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,273	0	82,686,369		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	333,570	0	3,525,585		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0		31.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	732,036	0	7,983,650		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	105,211	0	22,020,514		54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	8,777	0	756,455		54.03
60.00	06000	LABORATORY	624,645	0	13,161,990		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	2,647	0	151,728		62.00
65.00	06500	RESPIRATORY THERAPY	50,135	0	4,926,473		65.00
66.00	06600	PHYSICAL THERAPY	111,511	0	9,084,939		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	613,852	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	101,399	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	100	11,136,763		73.00
76.00	03480	INFUSION THERAPY	142,582	0	572,820		76.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	36,792	0	0		88.00
88.01	08801	RURAL HEALTH CLINIC II	37,227	0	0		88.01
90.00	09000	CLINIC	47,924	0	225,080		90.00
90.01	09001	DIABETES	0	0	16,608		90.01
90.02	09002	OP PSYCH	0	0	0		90.02
90.03	09003	PAIN MANAGEMENT	3,309	0	198,147		90.03
91.00	09100	EMERGENCY	609,086	0	8,925,617		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
		OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	23,606	0	0		101.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,621,959	100	82,686,369		118.00
		NONREIMBURSABLE COST CENTERS					
194.00	07950	MOB	43,858	0	0		194.00
194.01	07951	FOUNDATION	0	0	0		194.01
194.02	07952	ASC	0	0	0		194.02
194.03	07953	SNF - PERRY CO.	0	0	0		194.03
194.04	07954	TELE BEHAVIORAL	0	0	0		194.04
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)	719,643	4,568,653	354,812		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.196312	45,686.530000	0.004291		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	128,664	62,922	48,543		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.035098	629.220000	0.000587		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: 15-1319 | Period: From 10/01/2021 To 09/30/2022 | Worksheet C Part I Date/Time Prepared: 2/23/2023 3:14 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,954,589		6,954,589	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0		0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,905,809		2,905,809	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,082,544		3,082,544	0	0	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	232,619		232,619	0	0	54.03
60.00	06000	LABORATORY	4,706,447		4,706,447	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	57,696		57,696	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	1,308,879	0	1,308,879	0	0	65.00
66.00	06600	PHYSICAL THERAPY	3,099,473	0	3,099,473	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0		0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	857,630		857,630	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	141,667		141,667	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,616,441		4,616,441	0	0	73.00
76.00	03480	INFUSION THERAPY	580,648		580,648	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,078,397		1,078,397	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	1,598,645		1,598,645	0	0	88.01
90.00	09000	CLINIC	222,427		222,427	0	0	90.00
90.01	09001	DIABETES	695		695	0	0	90.01
90.02	09002	OP PSYCH	0		0	0	0	90.02
90.03	09003	PAIN MANAGEMENT	525,183		525,183	0	0	90.03
91.00	09100	EMERGENCY	5,936,082		5,936,082	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,362,690		2,362,690		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,347,962		1,347,962		0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	41,616,523	0	41,616,523	0	0	200.00
201.00		Less Observation Beds	2,362,690		2,362,690		0	201.00
202.00		Total (see instructions)	39,253,833	0	39,253,833	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1319 | Period: From 10/01/2021 To 09/30/2022 | Worksheet C Part I Date/Time Prepared: 2/23/2023 3:14 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,329,905		2,329,905			30.00
31.00	03100	INTENSIVE CARE UNIT	0		0			31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	86,373	6,538,411	6,624,784	0.438627	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	340,785	20,347,945	20,688,730	0.148996	0.000000	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	6,453	749,999	756,452	0.307513	0.000000	54.03
60.00	06000	LABORATORY	527,183	12,635,416	13,162,599	0.357562	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	31,107	179,121	210,228	0.274445	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	509,783	3,538,325	4,048,108	0.323331	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,634,236	7,522,843	9,157,079	0.338478	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	283,617	283,353	566,970	1.512655	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	354,896	354,896	0.399179	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	722,565	11,820,514	12,543,079	0.368047	0.000000	73.00
76.00	03480	INFUSION THERAPY	8,729	625,952	634,681	0.914866	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	1,284,757	1,284,757			88.00
88.01	08801	RURAL HEALTH CLINIC II	0	2,182,154	2,182,154			88.01
90.00	09000	CLINIC	0	229,144	229,144	0.970687	0.000000	90.00
90.01	09001	DIABETES	0	16,608	16,608	0.041847	0.000000	90.01
90.02	09002	OP PSYCH	0	0	0	0.000000	0.000000	90.02
90.03	09003	PAIN MANAGEMENT	0	198,147	198,147	2.650472	0.000000	90.03
91.00	09100	EMERGENCY	196,804	8,534,375	8,731,179	0.679872	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	43,725	1,089,281	1,133,006	2.085329	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	888,117	888,117			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	6,721,265	79,019,358	85,740,623			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	6,721,265	79,019,358	85,740,623			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1319 | Period: From 10/01/2021 To 09/30/2022 | Worksheet C Part I Date/Time Prepared: 2/23/2023 3:14 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
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0.000000		54.03
60.00	06000	LABORATORY	0.000000		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000		62.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03480	INFUSION THERAPY	0.000000		76.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC			88.00
88.01	08801	RURAL HEALTH CLINIC II			88.01
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	DIABETES	0.000000		90.01
90.02	09002	OP PSYCH	0.000000		90.02
90.03	09003	PAIN MANAGEMENT	0.000000		90.03
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY			101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1319 | Period: From 10/01/2021 To 09/30/2022 | Worksheet C Part I Date/Time Prepared: 2/23/2023 3:14 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	6,954,589		6,954,589	0	6,954,589	30.00
31.00	03100	INTENSIVE CARE UNIT	0		0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,905,809		2,905,809	0	2,905,809	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,082,544		3,082,544	0	3,082,544	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	232,619		232,619	0	232,619	54.03
60.00	06000	LABORATORY	4,706,447		4,706,447	0	4,706,447	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	57,696		57,696	0	57,696	62.00
65.00	06500	RESPIRATORY THERAPY	1,308,879	0	1,308,879	0	1,308,879	65.00
66.00	06600	PHYSICAL THERAPY	3,099,473	0	3,099,473	0	3,099,473	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0		0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	857,630		857,630	0	857,630	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	141,667		141,667	0	141,667	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,616,441		4,616,441	0	4,616,441	73.00
76.00	03480	INFUSION THERAPY	580,648		580,648	0	580,648	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,078,397		1,078,397	0	1,078,397	88.00
88.01	08801	RURAL HEALTH CLINIC II	1,598,645		1,598,645	0	1,598,645	88.01
90.00	09000	CLINIC	222,427		222,427	0	222,427	90.00
90.01	09001	DIABETES	695		695	0	695	90.01
90.02	09002	OP PSYCH	0		0	0	0	90.02
90.03	09003	PAIN MANAGEMENT	525,183		525,183	0	525,183	90.03
91.00	09100	EMERGENCY	5,936,082		5,936,082	0	5,936,082	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,362,690		2,362,690		2,362,690	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,347,962		1,347,962		1,347,962	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	41,616,523	0	41,616,523	0	41,616,523	200.00
201.00		Less Observation Beds	2,362,690		2,362,690		2,362,690	201.00
202.00		Total (see instructions)	39,253,833	0	39,253,833	0	39,253,833	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1319 | Period: From 10/01/2021 To 09/30/2022 | Worksheet C Part I Date/Time Prepared: 2/23/2023 3:14 pm

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,329,905		2,329,905			30.00
31.00	03100	INTENSIVE CARE UNIT	0		0			31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	86,373	6,538,411	6,624,784	0.438627	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	340,785	20,347,945	20,688,730	0.148996	0.000000	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	6,453	749,999	756,452	0.307513	0.000000	54.03
60.00	06000	LABORATORY	527,183	12,635,416	13,162,599	0.357562	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	31,107	179,121	210,228	0.274445	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	509,783	3,538,325	4,048,108	0.323331	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,634,236	7,522,843	9,157,079	0.338478	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	283,617	283,353	566,970	1.512655	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	354,896	354,896	0.399179	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	722,565	11,820,514	12,543,079	0.368047	0.000000	73.00
76.00	03480	INFUSION THERAPY	8,729	625,952	634,681	0.914866	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	1,284,757	1,284,757	0.839378	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	2,182,154	2,182,154	0.732600	0.000000	88.01
90.00	09000	CLINIC	0	229,144	229,144	0.970687	0.000000	90.00
90.01	09001	DIABETES	0	16,608	16,608	0.041847	0.000000	90.01
90.02	09002	OP PSYCH	0	0	0	0.000000	0.000000	90.02
90.03	09003	PAIN MANAGEMENT	0	198,147	198,147	2.650472	0.000000	90.03
91.00	09100	EMERGENCY	196,804	8,534,375	8,731,179	0.679872	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	43,725	1,089,281	1,133,006	2.085329	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	888,117	888,117			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	6,721,265	79,019,358	85,740,623			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	6,721,265	79,019,358	85,740,623			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1319 | Period: From 10/01/2021 To 09/30/2022 | Worksheet C Part I Date/Time Prepared: 2/23/2023 3:14 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
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0.000000		54.03
60.00	06000	LABORATORY	0.000000		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000		62.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03480	INFUSION THERAPY	0.000000		76.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		88.01
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	DIABETES	0.000000		90.01
90.02	09002	OP PSYCH	0.000000		90.02
90.03	09003	PAIN MANAGEMENT	0.000000		90.03
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY			101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-1319 | Period: From 10/01/2021 To 09/30/2022 | Worksheet D Part II Date/Time Prepared: 2/23/2023 3:14 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	232,622	6,624,784	0.035114	16,835	591	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	160,276	20,688,730	0.007747	55,507	430	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	15,952	756,452	0.021088	5,264	111	54.03
60.00	06000	LABORATORY	106,775	13,162,599	0.008112	128,158	1,040	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	331	210,228	0.001574	4,284	7	62.00
65.00	06500	RESPIRATORY THERAPY	71,313	4,048,108	0.017616	67,942	1,197	65.00
66.00	06600	PHYSICAL THERAPY	157,342	9,157,079	0.017183	42,118	724	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	23,482	566,970	0.041417	50,530	2,093	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,879	354,896	0.010930	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	69,459	12,543,079	0.005538	200,868	1,112	73.00
76.00	03480	INFUSION THERAPY	45,759	634,681	0.072098	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	4,721	1,284,757	0.003675	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	56,685	2,182,154	0.025977	0	0	88.01
90.00	09000	CLINIC	3,542	229,144	0.015458	0	0	90.00
90.01	09001	DIABETES	12	16,608	0.000723	0	0	90.01
90.02	09002	OP PSYCH	0	0	0.000000	0	0	90.02
90.03	09003	PAIN MANAGEMENT	57,535	198,147	0.290365	0	0	90.03
91.00	09100	EMERGENCY	327,623	8,731,179	0.037523	3,825	144	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	184,614	1,133,006	0.162942	404	66	92.00
200.00		Total (lines 50 through 199)	1,521,922	82,522,601		575,735	7,515	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1319 | Period: From 10/01/2021 To 09/30/2022 | Worksheet D Part IV Date/Time Prepared: 2/23/2023 3:14 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	0	0	0	0	54.03
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03480	INFUSION THERAPY	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	DIABETES	0	0	0	0	0	90.01
90.02	09002	OP PSYCH	0	0	0	0	0	90.02
90.03	09003	PAIN MANAGEMENT	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
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: 15-1319 | Period: From 10/01/2021 To 09/30/2022 | Worksheet D Part IV | Date/Time Prepared: 2/23/2023 3:14 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	6,624,784	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	20,688,730	0.000000	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	0	0	756,452	0.000000	54.03
60.00	06000	LABORATORY	0	0	0	13,162,599	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	210,228	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	4,048,108	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	9,157,079	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	566,970	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	354,896	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	12,543,079	0.000000	73.00
76.00	03480	INFUSION THERAPY	0	0	0	634,681	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	1,284,757	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	2,182,154	0.000000	88.01
90.00	09000	CLINIC	0	0	0	229,144	0.000000	90.00
90.01	09001	DIABETES	0	0	0	16,608	0.000000	90.01
90.02	09002	OP PSYCH	0	0	0	0	0.000000	90.02
90.03	09003	PAIN MANAGEMENT	0	0	0	198,147	0.000000	90.03
91.00	09100	EMERGENCY	0	0	0	8,731,179	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	1,133,006	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	82,522,601		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1319 | Period: From 10/01/2021 To 09/30/2022 | Worksheet D Part IV | Date/Time Prepared: 2/23/2023 3:14 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	16,835	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	55,507	0	0	0	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0.000000	5,264	0	0	0	54.03
60.00	06000	LABORATORY	0.000000	128,158	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	4,284	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.000000	67,942	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	42,118	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	50,530	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	200,868	0	0	0	73.00
76.00	03480	INFUSION THERAPY	0.000000	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000	0	0	0	0	88.01
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	DIABETES	0.000000	0	0	0	0	90.01
90.02	09002	OP PSYCH	0.000000	0	0	0	0	90.02
90.03	09003	PAIN MANAGEMENT	0.000000	0	0	0	0	90.03
91.00	09100	EMERGENCY	0.000000	3,825	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	404	0	0	0	92.00
200.00		Total (lines 50 through 199)		575,735	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1319 | Period: From 10/01/2021 To 09/30/2022 | Worksheet D Part V Date/Time Prepared: 2/23/2023 3:14 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	0.438627	0	1,806,242	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.148996	0	4,742,144	0	0	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0.307513	0	233,225	0	0	54.03
60.00	06000	LABORATORY	0.357562	0	2,555,737	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.274445	0	37,914	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.323331	0	1,203,521	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.338478	0	2,038,318	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1.512655	0	91,360	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.399179	0	160,220	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.368047	0	5,065,356	246	0	73.00
76.00	03480	INFUSION THERAPY	0.914866	0	222,466	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC						88.00
88.01	08801	RURAL HEALTH CLINIC II						88.01
90.00	09000	CLINIC	0.970687	0	54,065	0	0	90.00
90.01	09001	DIABETES	0.041847	0	6,391	0	0	90.01
90.02	09002	OP PSYCH	0.000000	0	0	0	0	90.02
90.03	09003	PAIN MANAGEMENT	2.650472	0	55,295	0	0	90.03
91.00	09100	EMERGENCY	0.679872	0	1,420,861	2,877	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2.085329	0	332,901	0	0	92.00
200.00		Subtotal (see instructions)		0	20,026,016	3,123	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	20,026,016	3,123	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1319 | Period: From 10/01/2021 To 09/30/2022 | Worksheet D Part V Date/Time Prepared: 2/23/2023 3:14 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	792,267	0		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	706,560	0		54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	71,720	0		54.03
60.00	06000	LABORATORY	913,834	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	10,405	0		62.00
65.00	06500	RESPIRATORY THERAPY	389,136	0		65.00
66.00	06600	PHYSICAL THERAPY	689,926	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	138,196	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	63,956	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,864,289	91		73.00
76.00	03480	INFUSION THERAPY	203,527	0		76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC				88.00
88.01	08801	RURAL HEALTH CLINIC II				88.01
90.00	09000	CLINIC	52,480	0		90.00
90.01	09001	DIABETES	267	0		90.01
90.02	09002	OP PSYCH	0	0		90.02
90.03	09003	PAIN MANAGEMENT	146,558	0		90.03
91.00	09100	EMERGENCY	966,004	1,956		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	694,208	0		92.00
200.00		Subtotal (see instructions)	7,703,333	2,047		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	7,703,333	2,047		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1319 | Period: From 10/01/2021 To 09/30/2022 | Worksheet D-1 | Date/Time Prepared: 2/23/2023 3:14 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)	3,729	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,620	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)	676	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	285	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)	777	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	244	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)	803	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	256	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)	285	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)	777	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	231.10	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	231.10	20.00
21.00	Total general inpatient routine service cost (see instructions)	6,954,589	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)	56,388	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)	185,573	25.00
26.00	Total swing-bed cost (see instructions)	2,899,977	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	4,054,612	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)	4,054,612	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)	2,502.84	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	640,727	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)	640,727	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1319 | Period: From 10/01/2021 To 09/30/2022 | Worksheet D-1 | Date/Time Prepared: 2/23/2023 3:14 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						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)	254,303	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	895,030	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
56.00	Target amount (line 54 x line 55)	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	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 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)	713,309	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	1,944,707	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	2,658,016	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)	944	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,502.85	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	2,362,690	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1319 | Period: From 10/01/2021 To 09/30/2022 | Worksheet D-1 | Date/Time Prepared: 2/23/2023 3:14 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	543,411	6,954,589	0.078137	2,362,690	184,614	90.00
91.00	Nursing Program cost	0	6,954,589	0.000000	2,362,690	0	91.00
92.00	Allied health cost	0	6,954,589	0.000000	2,362,690	0	92.00
93.00	All other Medical Education	0	6,954,589	0.000000	2,362,690	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1319 | Period: From 10/01/2021 To 09/30/2022 | Worksheet D-1 | Date/Time Prepared: 2/23/2023 3:14 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)	3,729	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,620	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)	676	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	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)	1,062	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	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)	1,047	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	18	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	6,954,589	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)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	2,753,830	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	4,200,759	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)	4,200,759	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)	2,593.06	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	46,675	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)	46,675	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1319 | Period: From 10/01/2021 To 09/30/2022 | Worksheet D-1 | Date/Time Prepared: 2/23/2023 3:14 pm

Title XIX | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						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)	4,661	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	51,336	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
56.00	Target amount (line 54 x line 55)	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	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 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)	944	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,593.06	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	2,447,849	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1319 | Period: From 10/01/2021 To 09/30/2022 | Worksheet D-1 | Date/Time Prepared: 2/23/2023 3:14 pm

Title XIX | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	543,411	6,954,589	0.078137	2,447,849	191,268	90.00
91.00	Nursing Program cost	0	6,954,589	0.000000	2,447,849	0	91.00
92.00	Allied health cost	0	6,954,589	0.000000	2,447,849	0	92.00
93.00	All other Medical Education	0	6,954,589	0.000000	2,447,849	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1319 | Period: From 10/01/2021 To 09/30/2022 | Worksheet D-3 | Date/Time Prepared: 2/23/2023 3:14 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		245,829		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.438627	16,835	7,384	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.148996	55,507	8,270	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0.307513	5,264	1,619	54.03
60.00	06000	LABORATORY	0.357562	128,158	45,824	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.274445	4,284	1,176	62.00
65.00	06500	RESPIRATORY THERAPY	0.323331	67,942	21,968	65.00
66.00	06600	PHYSICAL THERAPY	0.338478	42,118	14,256	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1.512655	50,530	76,434	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.399179	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.368047	200,868	73,929	73.00
76.00	03480	INFUSION THERAPY	0.914866	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0	88.01
90.00	09000	CLINIC	0.970687	0	0	90.00
90.01	09001	DIABETES	0.041847	0	0	90.01
90.02	09002	OP PSYCH	0.000000	0	0	90.02
90.03	09003	PAIN MANAGEMENT	2.650472	0	0	90.03
91.00	09100	EMERGENCY	0.679872	3,825	2,601	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2.085329	404	842	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		575,735	254,303	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)		575,735		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1319 | Component CCN: 15-Z319 | Period: From 10/01/2021 To 09/30/2022 | Worksheet D-3 | Date/Time Prepared: 2/23/2023 3:14 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
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.438627	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.148996	15,843	2,361	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0.307513	0	0	54.03
60.00	06000	LABORATORY	0.357562	121,010	43,269	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.274445	2,142	588	62.00
65.00	06500	RESPIRATORY THERAPY	0.323331	92,016	29,752	65.00
66.00	06600	PHYSICAL THERAPY	0.338478	829,253	280,684	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1.512655	81,840	123,796	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.399179	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.368047	380,193	139,929	73.00
76.00	03480	INFUSION THERAPY	0.914866	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0	88.01
90.00	09000	CLINIC	0.970687	0	0	90.00
90.01	09001	DIABETES	0.041847	0	0	90.01
90.02	09002	OP PSYCH	0.000000	0	0	90.02
90.03	09003	PAIN MANAGEMENT	2.650472	0	0	90.03
91.00	09100	EMERGENCY	0.679872	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2.085329	180	375	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,522,477	620,754	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		1,522,477		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1319 | Period: From 10/01/2021 To 09/30/2022 | Worksheet D-3 | Date/Time Prepared: 2/23/2023 3:14 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		4,293		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.438627	1,665	730	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.148996	2,057	306	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0.307513	157	48	54.03
60.00	06000	LABORATORY	0.357562	4,602	1,646	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.274445	88	24	62.00
65.00	06500	RESPIRATORY THERAPY	0.323331	2,049	663	65.00
66.00	06600	PHYSICAL THERAPY	0.338478	136	46	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1.512655	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.399179	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.368047	0	0	73.00
76.00	03480	INFUSION THERAPY	0.914866	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.839378	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.732600	0	0	88.01
90.00	09000	CLINIC	0.970687	0	0	90.00
90.01	09001	DIABETES	0.041847	0	0	90.01
90.02	09002	OP PSYCH	0.000000	0	0	90.02
90.03	09003	PAIN MANAGEMENT	2.650472	0	0	90.03
91.00	09100	EMERGENCY	0.679872	1,762	1,198	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2.085329	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		12,516	4,661	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)		12,516		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-1319 | Period: From 10/01/2021 To 09/30/2022 | Worksheet E Part B Date/Time Prepared: 2/23/2023 3:14 pm

Title XVIII | Hospital | Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	7,705,380	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	OPPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	7,705,380	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	7,782,434	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)	66,606	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	3,446,262	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)	4,269,566	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)	4,269,566	30.00
31.00	Primary payer payments	8,471	31.00
32.00	Subtotal (line 30 minus line 31)	4,261,095	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)	265,033	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	172,271	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	241,041	36.00
37.00	Subtotal (see instructions)	4,433,366	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
39.97	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)	4,433,366	40.00
40.01	Sequestration adjustment (see instructions)	33,250	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		40.03
41.00	Interim payments	4,303,062	41.00
41.01	Interim payments-PARHM		41.01
42.00	Tentative settlement (for contractors use only)	0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)		42.01
43.00	Balance due provider/program (see instructions)	97,054	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: 15-1319	Period: From 10/01/2021 To 09/30/2022	Worksheet E Part B Date/Time Prepared: 2/23/2023 3:14 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: 15-1319 | Period: From 10/01/2021 To 09/30/2022 | Worksheet E-1 Part I Date/Time Prepared: 2/23/2023 3:14 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		791,085		4,303,062	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)		791,085		4,303,062	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		25,051		97,054	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		816,136		4,400,116	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: 15-1319 | Component CCN: 15-Z319 | Period: From 10/01/2021 To 09/30/2022 | Worksheet E-1 Part I | Date/Time Prepared: 2/23/2023 3:14 pm

Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		2,892,467		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)		2,892,467		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		374,931		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		3,267,398		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: 15-1319	Period: From 10/01/2021 To 09/30/2022	Worksheet E-1 Part II Date/Time Prepared: 2/23/2023 3:14 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 (Wkst. S-3, Pt. I, col. 6, sum of lines 1, and 8 through 12, and plus for cost reporting periods beginning on or after 10/01/2013, line 32)		2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2		3.00
4.00	Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of lines 1, and 8 through 12, and plus for cost reporting periods beginning on or after 10/01/2013, line 32)		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: 15-1319 | Component CCN: 15-Z319 | Period: From 10/01/2021 To 09/30/2022 | Worksheet E-2 | Date/Time Prepared: 2/23/2023 3:14 pm

Title XVIII | Swing Beds - SNF | Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	2,684,596	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)	626,962	0	3.00
3.01	Nursing and allied health payment-PARHM (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	1,062	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)	3,311,558	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	3,311,558	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)	3,311,558	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	19,470	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (see instructions)	3,292,088	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)	3,292,088	0	19.00
19.01	Sequestration adjustment (see instructions)	24,690	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0	0	19.02
19.03	Sequestration adjustment-PARHM pass-throughs			19.03
19.25	Sequestration for non-claims based amounts (see instructions)	0	0	19.25
20.00	Interim payments	2,892,467	0	20.00
20.01	Interim payments-PARHM			20.01
21.00	Tentative settlement (for contractor use only)	0	0	21.00
21.01	Tentative settlement-PARHM (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)	374,931	0	22.00
22.01	Balance due provider/program-PARHM (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: 15-1319	Period: From 10/01/2021 To 09/30/2022	Worksheet E-3 Part V Date/Time Prepared: 2/23/2023 3:14 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	895,030	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)	0	2.00
3.00	Organ acquisition	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	895,030	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	903,980	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)	903,980	19.00
20.00	Deductibles (exclude professional component)	88,807	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	815,173	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	815,173	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	10,970	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	7,131	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	7,420	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	822,304	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)	822,304	30.00
30.01	Sequestration adjustment (see instructions)	6,168	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
30.03	Sequestration adjustment-PARHM		30.03
31.00	Interim payments	791,085	31.00
31.01	Interim payments-PARHM		31.01
32.00	Tentative settlement (for contractor use only)	0	32.00
32.01	Tentative settlement-PARHM (for contractor use only)		32.01
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)	25,051	33.00
33.01	Balance due provider/program-PARHM (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: 15-1319	Period: From 10/01/2021 To 09/30/2022	Worksheet E-3 Part VII Date/Time Prepared: 2/23/2023 3:14 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	51,336		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	51,336	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)	51,336	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	4,293		8.00
9.00	Ancillary service charges	12,516	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)	16,809	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)	16,809	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	0	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	34,527	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)	51,336	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)	51,336	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	34,527	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	51,336	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)	51,336	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	51,336	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)	51,336	0	40.00
41.00	Interim payments	4,202	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	47,134	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: 15-1319 | Period: From 10/01/2021 To 09/30/2022 | Worksheet G | Date/Time Prepared: 2/23/2023 3:14 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	26,213,505	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	6,026,758	0	0	0	4.00
5.00	Other receivable	734,903	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-3,239,868	0	0	0	6.00
7.00	Inventory	772,762	0	0	0	7.00
8.00	Prepaid expenses	676,581	0	0	0	8.00
9.00	Other current assets	677,088	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)	31,861,729	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	421,244	0	0	0	12.00
13.00	Land improvements	7,898,966	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	1,098,593	0	0	0	15.00
16.00	Accumulated depreciation	-1,111,750	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	9,245,407	0	0	0	19.00
20.00	Accumulated depreciation	-3,002,511	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	0	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	14,549,949	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	2,606,057	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	2,606,057	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	49,017,735	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	3,049,244	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,941,036	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	-1,486,470	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	4,527,107	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	8,030,917	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	10,847,756	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)	10,847,756	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	18,878,673	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	30,139,062				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)	30,139,062	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	49,017,735	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-1319 | Period: From 10/01/2021 To 09/30/2022 | Worksheet G-1 | Date/Time Prepared: 2/23/2023 3:14 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		21,177,893		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		8,961,169				2.00
3.00	Total (sum of line 1 and line 2)		30,139,062		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)		30,139,062		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)		30,139,062		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: 15-1319 | Period: From 10/01/2021 To 09/30/2022 | Worksheet G-2 Parts I & II Date/Time Prepared: 2/23/2023 3:14 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	3,525,585		3,525,585	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)	3,525,585		3,525,585	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	0		0	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	3,525,585		3,525,585	17.00
18.00	Ancillary services	1,336,613	68,704,967	70,041,580	18.00
19.00	Outpatient services	207,432	8,943,265	9,150,697	19.00
20.00	RURAL HEALTH CLINIC	0	1,284,757	1,284,757	20.00
20.01	RURAL HEALTH CLINIC II	0	2,182,154	2,182,154	20.01
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		888,117	888,117	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	MOB	0	0	0	27.00
27.01	SNF PERRY CO	0	0	0	27.01
27.02	PRO FEES	0	1,115,394	1,115,394	27.02
27.03	PROFESSIONAL	0	4,630,464	4,630,464	27.03
27.04	C/C 199	0	0	0	27.04
27.05	TELE BH	0	0	0	27.05
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	5,069,630	87,749,118	92,818,748	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		42,030,346		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		42,030,346		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 15-1319	Period: From 10/01/2021 To 09/30/2022	Worksheet G-3 Date/Time Prepared: 2/23/2023 3:14 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	92,818,748	1.00
2.00	Less contractual allowances and discounts on patients' accounts	45,422,093	2.00
3.00	Net patient revenues (line 1 minus line 2)	47,396,655	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	42,030,346	4.00
5.00	Net income from service to patients (line 3 minus line 4)	5,366,309	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	94,207	6.00
7.00	Income from investments	310,453	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	116,747	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	116,790	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER OPERATING INCOME	2,844,908	24.00
24.50	COVID-19 PHE Funding	111,755	24.50
25.00	Total other income (sum of lines 6-24)	3,594,860	25.00
26.00	Total (line 5 plus line 25)	8,961,169	26.00
27.00	FOUNDATION SALARIES	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)	8,961,169	29.00

ANALYSIS OF HOSPITAL-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 15-1319 HHA CCN: 15-7445 | Period: From 10/01/2021 To 09/30/2022 | Worksheet H Date/Time Prepared: 2/23/2023 3:14 pm

Home Health Agency I | PPS

		Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of cols. 1 thru 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures			0		0	0	1.00
2.00	Capital Related - Movable Equipment			0		0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	0	4.00
5.00	Administrative and General	101,724	9,857	0	0	84,567	196,148	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	158,033	15,314	0	0	219,303	392,650	6.00
7.00	Physical Therapy	127,846	12,388	0	0	0	140,234	7.00
8.00	Occupational Therapy	84,390	8,177	0	0	0	92,567	8.00
9.00	Speech Pathology	12,207	1,183	0	0	0	13,390	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	36,791	3,565	0	0	0	40,356	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	30,908	30,908	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	520,991	50,484	0	0	334,778	906,253	24.00

		Reclassification	Reclassified Trial Balance (col. 6 + col.7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)			
		7.00	8.00	9.00	10.00			
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0	0	0			1.00
2.00	Capital Related - Movable Equipment	0	0	0	0			2.00
3.00	Plant Operation & Maintenance	0	0	0	0			3.00
4.00	Transportation	0	0	0	0			4.00
5.00	Administrative and General	0	196,148	-887	195,261			5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	392,650	0	392,650			6.00
7.00	Physical Therapy	0	140,234	0	140,234			7.00
8.00	Occupational Therapy	0	92,567	0	92,567			8.00
9.00	Speech Pathology	0	13,390	0	13,390			9.00
10.00	Medical Social Services	0	0	0	0			10.00
11.00	Home Health Aide	0	40,356	0	40,356			11.00
12.00	Supplies (see instructions)	0	0	0	0			12.00
13.00	Drugs	-7,863	23,045	0	23,045			13.00
14.00	DME	0	0	0	0			14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0			15.00
16.00	Respiratory Therapy	0	0	0	0			16.00
17.00	Private Duty Nursing	0	0	0	0			17.00
18.00	Clinic	0	0	0	0			18.00
19.00	Health Promotion Activities	0	0	0	0			19.00
20.00	Day Care Program	0	0	0	0			20.00
21.00	Home Delivered Meals Program	0	0	0	0			21.00
22.00	Homemaker Service	0	0	0	0			22.00
23.00	All Others (specify)	0	0	0	0			23.00
23.50	Telemedicine	0	0	0	0			23.50
24.00	Total (sum of lines 1-23)	-7,863	898,390	-887	897,503			24.00

Column, 6 line 24 should agree with the Worksheet A, column 3, line 101, or subscript as applicable.

COST ALLOCATION - HHA GENERAL SERVICE COST | Provider CCN: 15-1319 | HHA CCN: 15-7445 | Period: From 10/01/2021 To 09/30/2022 | Worksheet H-1 Part I | Date/Time Prepared: 2/23/2023 3:14 pm

Home Health Agency I | PPS

		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs: Bldgs & Fixtures	Capital Related Costs: Movable Equipment	Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)	
		0	1.00	2.00	3.00	4.00	4A.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0				0	1.00
2.00	Capital Related - Movable Equipment	0		0			0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0		0	3.00
4.00	Transportation	0	0	0	0	0		4.00
5.00	Administrative and General	195,261	0	0	0	0	195,261	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	392,650	0	0	0	0	392,650	6.00
7.00	Physical Therapy	140,234	0	0	0	0	140,234	7.00
8.00	Occupational Therapy	92,567	0	0	0	0	92,567	8.00
9.00	Speech Pathology	13,390	0	0	0	0	13,390	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	40,356	0	0	0	0	40,356	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	23,045	0	0	0		23,045	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	897,503	0	0	0	0	897,503	24.00

		Administrative & General	Total (cols. 4A + 5)		
		5.00	6.00		
	GENERAL SERVICE COST CENTERS				
1.00	Capital Related - Bldg. & Fixtures				1.00
2.00	Capital Related - Movable Equipment				2.00
3.00	Plant Operation & Maintenance				3.00
4.00	Transportation				4.00
5.00	Administrative and General	195,261			5.00
	HHA REIMBURSABLE SERVICES				
6.00	Skilled Nursing Care	109,177	501,827		6.00
7.00	Physical Therapy	38,993	179,227		7.00
8.00	Occupational Therapy	25,739	118,306		8.00
9.00	Speech Pathology	3,723	17,113		9.00
10.00	Medical Social Services	0	0		10.00
11.00	Home Health Aide	11,221	51,577		11.00
12.00	Supplies (see instructions)	0	0		12.00
13.00	Drugs	6,408	29,453		13.00
14.00	DME	0	0		14.00
	HHA NONREIMBURSABLE SERVICES				
15.00	Home Dialysis Aide Services	0	0		15.00
16.00	Respiratory Therapy	0	0		16.00
17.00	Private Duty Nursing	0	0		17.00
18.00	Clinic	0	0		18.00
19.00	Health Promotion Activities	0	0		19.00
20.00	Day Care Program	0	0		20.00
21.00	Home Delivered Meals Program	0	0		21.00
22.00	Homemaker Service	0	0		22.00
23.00	All Others (specify)	0	0		23.00
23.50	Telemedicine	0	0		23.50
24.00	Total (sum of lines 1-23)		897,503		24.00

COST ALLOCATION - HHA STATISTICAL BASIS | Provider CCN: 15-1319 | HHA CCN: 15-7445 | Period: From 10/01/2021 To 09/30/2022 | Worksheet H-1 Part II | Date/Time Prepared: 2/23/2023 3:14 pm

Home Health Agency I | PPS

		Capital Related Costs						
		Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)	Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
		1.00	2.00	3.00	4.00	5A.00	5.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0				0		1.00
2.00	Capital Related - Movable Equipment		0			0		2.00
3.00	Plant Operation & Maintenance	0	0	0		0		3.00
4.00	Transportation (see instructions)	0	0	0	0			4.00
5.00	Administrative and General	0	0	0	0	-195,261	702,242	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	392,650	6.00
7.00	Physical Therapy	0	0	0	0	0	140,234	7.00
8.00	Occupational Therapy	0	0	0	0	0	92,567	8.00
9.00	Speech Pathology	0	0	0	0	0	13,390	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	0	0	0	0	0	40,356	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0		0	23,045	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	0	0	0	0	-195,261	702,242	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		195,261	25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.278054	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 15-1319 HHA CCN: 15-7445

Period: From 10/01/2021 To 09/30/2022

Worksheet H-2 Part I Date/Time Prepared: 2/23/2023 3:14 pm

Home Health Agency I

PPS

	Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS BLDG & FIXT	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	
		0	1.00	4.00	4A	5.00	7.00	
1.00	Administrative and General	0	12,268	134,778	147,046	29,529	26,002	1.00
2.00	Skilled Nursing Care	501,827	0	0	501,827	100,774	0	2.00
3.00	Physical Therapy	179,227	0	0	179,227	35,991	0	3.00
4.00	Occupational Therapy	118,306	0	0	118,306	23,758	0	4.00
5.00	Speech Pathology	17,113	0	0	17,113	3,437	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	51,577	0	0	51,577	10,357	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	29,453	0	0	29,453	5,915	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	897,503	12,268	134,778	1,044,549	209,761	26,002	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.				0.000000			21.00

	Cost Center Description	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICE & SUPPLY	
		8.00	9.00	10.00	11.00	13.00	14.00	
1.00	Administrative and General	0	7,838	0	39,870	15,308	4,634	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	0	7,838	0	39,870	15,308	4,634	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 15-1319 HHA CCN: 15-7445

Period: From 10/01/2021 To 09/30/2022

Worksheet H-2 Part I Date/Time Prepared: 2/23/2023 3:14 pm

Home Health Agency I

PPS

	Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	Allocated HHA A&G (see Part II)	
		15.00	16.00	24.00	25.00	26.00	27.00	
1.00	Administrative and General	0	0	270,227	0	270,227		1.00
2.00	Skilled Nursing Care	0	0	602,601	0	602,601	151,093	2.00
3.00	Physical Therapy	0	0	215,218	0	215,218	53,963	3.00
4.00	Occupational Therapy	0	0	142,064	0	142,064	35,621	4.00
5.00	Speech Pathology	0	0	20,550	0	20,550	5,153	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	61,934	0	61,934	15,529	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	35,368	0	35,368	8,868	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	0	0	1,347,962	0	1,347,962	270,227	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.						0.250736	21.00

	Cost Center Description	Total HHA Costs	
		28.00	
1.00	Administrative and General		1.00
2.00	Skilled Nursing Care	753,694	2.00
3.00	Physical Therapy	269,181	3.00
4.00	Occupational Therapy	177,685	4.00
5.00	Speech Pathology	25,703	5.00
6.00	Medical Social Services	0	6.00
7.00	Home Health Aide	77,463	7.00
8.00	Supplies (see instructions)	0	8.00
9.00	Drugs	44,236	9.00
10.00	DME	0	10.00
11.00	Home Dialysis Aide Services	0	11.00
12.00	Respiratory Therapy	0	12.00
13.00	Private Duty Nursing	0	13.00
14.00	Clinic	0	14.00
15.00	Health Promotion Activities	0	15.00
16.00	Day Care Program	0	16.00
17.00	Home Delivered Meals Program	0	17.00
18.00	Homemaker Service	0	18.00
19.00	All Others (specify)	0	19.00
19.50	Telemedicine	0	19.50
20.00	Total (sum of lines 1-19) (2)	1,347,962	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.		21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 15-1319 | HHA CCN: 15-7445 | Period: From 10/01/2021 To 09/30/2022 | Worksheet H-2 Part II | Date/Time Prepared: 2/23/2023 3:14 pm

Home Health Agency I | PPS

	Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	
		1.00	4.00	5A	5.00	7.00	8.00	
1.00	Administrative and General	505	520,991	0	147,046	505	0	1.00
2.00	Skilled Nursing Care	0	0	0	501,827	0	0	2.00
3.00	Physical Therapy	0	0	0	179,227	0	0	3.00
4.00	Occupational Therapy	0	0	0	118,306	0	0	4.00
5.00	Speech Pathology	0	0	0	17,113	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	51,577	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	29,453	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	505	520,991		1,044,549	505	0	20.00
21.00	Total cost to be allocated	12,268	134,778		209,761	26,002	0	21.00
22.00	Unit cost multiplier	24.293069	0.258695		0.200815	51.489109	0.000000	22.00

	Cost Center Description	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	CAFETERIA (GROSS SALARIES)	NURSING ADMINISTRATION (NURSE SALARIES)	CENTRAL SERVICE & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
		9.00	10.00	11.00	13.00	14.00	15.00	
1.00	Administrative and General	505	0	520,991	471,231	23,606	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	505	0	520,991	471,231	23,606	0	20.00
21.00	Total cost to be allocated	7,838	0	39,870	15,308	4,634	0	21.00
22.00	Unit cost multiplier	15.520792	0.000000	0.076527	0.032485	0.196306	0.000000	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 15-1319 HHA CCN: 15-7445

Period: From 10/01/2021 To 09/30/2022

Worksheet H-2 Part II Date/Time Prepared: 2/23/2023 3:14 pm

Home Health Agency I

PPS

	Cost Center Description	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)				
		16.00				
1.00	Administrative and General	0				1.00
2.00	Skilled Nursing Care	0				2.00
3.00	Physical Therapy	0				3.00
4.00	Occupational Therapy	0				4.00
5.00	Speech Pathology	0				5.00
6.00	Medical Social Services	0				6.00
7.00	Home Health Aide	0				7.00
8.00	Supplies (see instructions)	0				8.00
9.00	Drugs	0				9.00
10.00	DME	0				10.00
11.00	Home Dialysis Aide Services	0				11.00
12.00	Respiratory Therapy	0				12.00
13.00	Private Duty Nursing	0				13.00
14.00	Clinic	0				14.00
15.00	Health Promotion Activities	0				15.00
16.00	Day Care Program	0				16.00
17.00	Home Delivered Meals Program	0				17.00
18.00	Homemaker Service	0				18.00
19.00	All Others (specify)	0				19.00
19.50	Telemedicine	0				19.50
20.00	Total (sum of lines 1-19)	0				20.00
21.00	Total cost to be allocated	0				21.00
22.00	Unit cost multiplier	0.000000				22.00

APPORTIONMENT OF PATIENT SERVICE COSTS | Provider CCN: 15-1319 HHA CCN: 15-7445 | Period: From 10/01/2021 To 09/30/2022 | Worksheet H-3 Part I Date/Time Prepared: 2/23/2023 3:14 pm

Title XVIII | Home Health Agency I | PPS

	Cost Center Description	From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	2.00	753,694		753,694	2,382	316.41	1.00
2.00	Physical Therapy	3.00	269,181	0	269,181	1,927	139.69	2.00
3.00	Occupational Therapy	4.00	177,685	0	177,685	1,272	139.69	3.00
4.00	Speech Pathology	5.00	25,703	0	25,703	184	139.69	4.00
5.00	Medical Social Services	6.00	0		0	0	0.00	5.00
6.00	Home Health Aide	7.00	77,463		77,463	142	545.51	6.00
7.00	Total (sum of lines 1-6)		1,303,726	0	1,303,726	5,907		7.00

	Cost Center Description	Cost Limits	CBSA No. (1)	Program Visits: Part A	Program Visits: Part B Not Subject to Deductibles & Coinsurance	Program Visits: Part B Subject to Deductibles		
		0	1.00	2.00	3.00	4.00	5.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care		99915	0	1,260			8.00
9.00	Physical Therapy		99915	0	1,086			9.00
10.00	Occupational Therapy		99915	0	732			10.00
11.00	Speech Pathology		99915	0	125			11.00
12.00	Medical Social Services		99915	0	0			12.00
13.00	Home Health Aide		99915	0	111			13.00
14.00	Total (sum of lines 8-13)			0	3,314			14.00

	Cost Center Description	From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Records)	Ratio (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	8.00	0	0	0	0	0.000000	15.00
16.00	Cost of Drugs	9.00	44,236	0	44,236	0	0.000000	16.00

	Cost Center Description	Program Visits: Part A	Program Visits: Part B Not Subject to Deductibles & Coinsurance	Program Visits: Part B Subject to Deductibles & Coinsurance	Cost of Services: Part A	Cost of Services: Part B Not Subject to Deductibles & Coinsurance	Cost of Services: Part B Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	0	1,260		0	398,677		1.00
2.00	Physical Therapy	0	1,086		0	151,703		2.00
3.00	Occupational Therapy	0	732		0	102,253		3.00
4.00	Speech Pathology	0	125		0	17,461		4.00
5.00	Medical Social Services	0	0		0	0		5.00
6.00	Home Health Aide	0	111		0	60,552		6.00
7.00	Total (sum of lines 1-6)	0	3,314		0	730,646		7.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 15-1319 | HHA CCN: 15-7445 | Period: From 10/01/2021 To 09/30/2022 | Worksheet H-3 Part I | Date/Time Prepared: 2/23/2023 3:14 pm

Title XVIII | Home Health Agency I | PPS

	Cost Center Description							
		6.00	7.00	8.00	9.00	10.00	11.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care							8.00
9.00	Physical Therapy							9.00
10.00	Occupational Therapy							10.00
11.00	Speech Pathology							11.00
12.00	Medical Social Services							12.00
13.00	Home Health Aide							13.00
14.00	Total (sum of lines 8-13)							14.00

	Cost Center Description	Program Covered Charges			Cost of Services			
			Part B			Part B		
		Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	0	0	0	0	0	0	15.00
16.00	Cost of Drugs		0	0		0	0	16.00

	Cost Center Description	Total Program Cost (sum of cols. 9-10)		
		12.00		
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION			
	Cost Per Visit Computation			
1.00	Skilled Nursing Care	398,677		1.00
2.00	Physical Therapy	151,703		2.00
3.00	Occupational Therapy	102,253		3.00
4.00	Speech Pathology	17,461		4.00
5.00	Medical Social Services	0		5.00
6.00	Home Health Aide	60,552		6.00
7.00	Total (sum of lines 1-6)	730,646		7.00

	Cost Center Description			
		12.00		
	Limitation Cost Computation			
8.00	Skilled Nursing Care			8.00
9.00	Physical Therapy			9.00
10.00	Occupational Therapy			10.00
11.00	Speech Pathology			11.00
12.00	Medical Social Services			12.00
13.00	Home Health Aide			13.00
14.00	Total (sum of lines 8-13)			14.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 15-1319
HHA CCN: 15-7445

Period:
From 10/01/2021
To 09/30/2022

Worksheet H-3
Part II
Date/Time Prepared:
2/23/2023 3:14 pm

Title XVIII | Home Health Agency I | PPS

	Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated		
		0	1.00	2.00	3.00	4.00		
	PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS							
1.00	Physical Therapy	66.00	0.338478	0	0	col. 2, line 2.00		1.00
2.00	Occupational Therapy	67.00	0.000000	0	0	col. 2, line 3.00		2.00
3.00	Speech Pathology	68.00	0.000000	0	0	col. 2, line 4.00		3.00
4.00	Cost of Medical Supplies	71.00	1.512655	0	0	col. 2, line 15.00		4.00
5.00	Cost of Drugs	73.00	0.368047	0	0	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1319 HHA CCN: 15-7445	Period: From 10/01/2021 To 09/30/2022	Worksheet H-4 Part I-II Date/Time Prepared: 2/23/2023 3:14 pm
	Title XVIII	Home Health Agency I	PPS

		Part A	Part B		
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		1.00	2.00	3.00	
	PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES				
	Reasonable Cost of Part A & Part B Services				
1.00	Reasonable cost of services (see instructions)	0	0	0	1.00
2.00	Total charges	0	0	0	2.00
	Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0	3.00
4.00	Amount 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(b)	0	0	0	4.00
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000	5.00
6.00	Total customary charges (see instructions)	0	0	0	6.00
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	0	0	7.00
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0	8.00
9.00	Primary payer amounts	0	0	0	9.00

		Part A Services	Part B Services	
		1.00	2.00	
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT			
10.00	Total reasonable cost (see instructions)	0	0	10.00
11.00	Total PPS Reimbursement - Full Episodes without Outliers	0	344,647	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers	0	105,128	12.00
13.00	Total PPS Reimbursement - LUPA Episodes	0	6,614	13.00
14.00	Total PPS Reimbursement - PEP Episodes	0	3,622	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	0	25,793	15.00
16.00	Total PPS Outlier Reimbursement - PEP Episodes	0	0	16.00
17.00	Total Other Payments	0	0	17.00
18.00	DME Payments	0	0	18.00
19.00	Oxygen Payments	0	0	19.00
20.00	Prosthetic and Orthotic Payments	0	0	20.00
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	21.00
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)	0	485,804	22.00
23.00	Excess reasonable cost (from line 8)	0	0	23.00
24.00	Subtotal (line 22 minus line 23)	0	485,804	24.00
25.00	Coinsurance billed to program patients (from your records)		0	25.00
26.00	Net cost (line 24 minus line 25)	0	485,804	26.00
27.00	Reimbursable bad debts (from your records)	0	0	27.00
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0	0	28.00
29.00	Total costs - current cost reporting period (line 26 plus line 27)	0	485,804	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	30.50
30.99	Demonstration payment adjustment amount before sequestration	0	0	30.99
31.00	Subtotal (see instructions)	0	485,804	31.00
31.01	Sequestration adjustment (see instructions)	0	4,092	31.01
31.02	Demonstration payment adjustment amount after sequestration	0	0	31.02
31.75	Sequestration adjustment for non-claims based amounts (see instructions)	0	0	31.75
32.00	Interim payments (see instructions)	0	481,712	32.00
33.00	Tentative settlement (for contractor use only)	0	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 32, and 33)	0	0	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	35.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED HHAs FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

Provider CCN: 15-1319 HHA CCN: 15-7445 | Period: From 10/01/2021 To 09/30/2022 | Worksheet H-5 Date/Time Prepared: 2/23/2023 3:14 pm

Home Health Agency I | PPS

		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		0		481,712	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			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			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. H-4, Part II, column as appropriate, line 32)		0		481,712	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		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50			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		0		0	6.02
7.00	Total Medicare program liability (see instructions)		0		481,712	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1319 | Component CCN: 15-8524 | Period: From 10/01/2021 To 09/30/2022 | Worksheet M-1 | Date/Time Prepared: 2/23/2023 3:14 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	0	0	0	0	0	1.00
2.00	Physician Assistant	0	0	0	149,647	149,647	2.00
3.00	Nurse Practitioner	314,891	0	314,891	-149,647	165,244	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)	314,891	0	314,891	0	314,891	10.00
11.00	Physician Services Under Agreement	0	0	0	29,210	29,210	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	29,210	29,210	14.00
15.00	Medical Supplies	0	94,896	94,896	-12,410	82,486	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	94,896	94,896	-12,410	82,486	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	314,891	94,896	409,787	16,800	426,587	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	169,454	169,454	-29,210	140,244	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	169,454	169,454	-29,210	140,244	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	13,747	13,747	0	13,747	29.00
30.00	Administrative Costs	103,739	142,153	245,892	-3,371	242,521	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	103,739	155,900	259,639	-3,371	256,268	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	418,630	420,250	838,880	-15,781	823,099	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1319 | Component CCN: 15-8524 | Period: From 10/01/2021 To 09/30/2022 | Worksheet M-1 | Date/Time Prepared: 2/23/2023 3:14 pm

RHC I | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	0		1.00
2.00	Physician Assistant	0	149,647		2.00
3.00	Nurse Practitioner	0	165,244		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)	0	314,891		10.00
11.00	Physician Services Under Agreement	0	29,210		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	29,210		14.00
15.00	Medical Supplies	0	82,486		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	82,486		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	426,587		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	140,244		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	140,244		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	13,747		29.00
30.00	Administrative Costs	-39,358	203,163		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-39,358	216,910		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-39,358	783,741		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1319 | Component CCN: 15-8553 | Period: From 10/01/2021 To 09/30/2022 | Worksheet M-1 | Date/Time Prepared: 2/23/2023 3:14 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	409,218	0	409,218	0	409,218	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	102,321	0	102,321	0	102,321	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	116,041	0	116,041	0	116,041	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)	627,580	0	627,580	0	627,580	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	124,243	124,243	-12,296	111,947	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	124,243	124,243	-12,296	111,947	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	627,580	124,243	751,823	-12,296	739,527	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	9,913	9,913	-9,913	0	29.00
30.00	Administrative Costs	142,311	203,147	345,458	-11,471	333,987	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	142,311	213,060	355,371	-21,384	333,987	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	769,891	337,303	1,107,194	-33,680	1,073,514	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1319 | Component CCN: 15-8553 | Period: From 10/01/2021 To 09/30/2022 | Worksheet M-1 | Date/Time Prepared: 2/23/2023 3:14 pm

RHC II | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	409,218		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	102,321		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	116,041		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	627,580		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	111,947		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	111,947		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	739,527		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	-62,806	271,181		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-62,806	271,181		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-62,806	1,010,708		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-1319 Component CCN: 15-8524

Period: From 10/01/2021 To 09/30/2022

Worksheet M-2 Date/Time Prepared: 2/23/2023 3:14 pm

RHC I

Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.00	0	1	0		1.00
2.00	Physician Assistant	0.81	1,601	1	1		2.00
3.00	Nurse Practitioner	0.90	1,759	1	1		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.71	3,360		2	3,360	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)	1.71	3,360			3,360	8.00
9.00	Physician Services Under Agreements		193			193	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)					426,587	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					140,244	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					566,831	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.752582	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					216,910	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					294,656	15.00
16.00	Total overhead (sum of lines 14 and 15)					511,566	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					511,566	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					384,995	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					811,582	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES | Provider CCN: 15-1319 | Component CCN: 15-8553 | Period: From 10/01/2021 To 09/30/2022 | Worksheet M-2 | Date/Time Prepared: 2/23/2023 3:14 pm

RHC II | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	1.65	5,133	1	2		1.00
2.00	Physician Assistant	0.00	0	1	0		2.00
3.00	Nurse Practitioner	0.81	2,307	1	1		3.00
4.00	Subtotal (sum of lines 1 through 3)	2.46	7,440		3	7,440	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)	2.46	7,440			7,440	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)					739,527	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)					739,527	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)					271,181	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					587,937	15.00
16.00	Total overhead (sum of lines 14 and 15)					859,118	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					859,118	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					859,118	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					1,598,645	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 15-1319 Component CCN: 15-8524	Period: From 10/01/2021 To 09/30/2022	Worksheet M-3 Date/Time Prepared: 2/23/2023 3:14 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)				811,582	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)				22,099	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)				789,483	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)				3,360	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)				193	5.00
6.00	Total adjusted visits (line 4 plus line 5)				3,553	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)				222.20	7.00
		Calculation of Limit (1)				
		Rate Period 1 (10/01/2021 through 12/31/2021)	Rate Period 2 (01/01/2022 through 09/30/2022)			
		1.00	2.00			
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	272.92	278.65	8.00		
9.00	Rate for Program covered visits (see instructions)	222.20	222.20	9.00		
	CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)	76	253	10.00		
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	16,887	56,217	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	73,104	16.00		
16.01	Total program charges (see instructions)(from contractor's records)		77,049	16.01		
16.02	Total program preventive charges (see instructions)(from provider's records)		12,084	16.02		
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		11,465	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.)		42,151	16.04		
16.05	Total program cost (see instructions)	0	53,616	16.05		
17.00	Primary payer amounts		0	17.00		
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		8,950	18.00		
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		11,203	19.00		
20.00	Net Medicare cost excluding vaccines (see instructions)		53,616	20.00		
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		4,866	21.00		
22.00	Total reimbursable Program cost (line 20 plus line 21)		58,482	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)		58,482	26.00		
26.01	Sequestration adjustment (see instructions)		438	26.01		
26.02	Demonstration payment adjustment amount after sequestration		0	26.02		
27.00	Interim payments		67,720	27.00		
28.00	Tentative settlement (for contractor use only)		0	28.00		
29.00	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)		-9,676	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: 15-1319 Component CCN: 15-8553	Period: From 10/01/2021 To 09/30/2022	Worksheet M-3 Date/Time Prepared: 2/23/2023 3:14 pm
	Title XVIII	RHC II	Cost

				1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			1,598,645	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			101,474	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			1,497,171	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			7,440	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)			7,440	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			201.23	7.00
		Calculation of Limit (1)			
		Rate Period 1 (10/01/2021 through 12/31/2021)	Rate Period 2 (01/01/2022 through 09/30/2022)		
		1.00	2.00		
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	224.81	229.53		8.00
9.00	Rate for Program covered visits (see instructions)	201.23	201.23		9.00
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	340	1,049		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	68,418	211,090		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	279,508		16.00
16.01	Total program charges (see instructions)(from contractor's records)		343,001		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		63,083		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		51,406		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.)		159,945		16.04
16.05	Total program cost (see instructions)	0	211,351		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		28,171		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		50,341		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		211,351		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		22,256		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		233,607		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)		233,607		26.00
26.01	Sequestration adjustment (see instructions)		1,752		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		240,345		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)		-8,490		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: 15-1319 | Component CCN: 15-8524 | Period: From 10/01/2021 To 09/30/2022 | Worksheet M-4 | Date/Time Prepared: 2/23/2023 3:14 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)	314,891	314,891	314,891	314,891	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000937	0.004732	0.011527	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	295	1,490	3,630	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	2,963	3,238	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	3,258	4,728	3,630	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	426,587	426,587	426,587	426,587	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	384,995	384,995	384,995	384,995	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.007637	0.011083	0.008509	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	2,940	4,267	3,276	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	6,198	8,995	6,906	0	10.00
11.00	Total number of injections/infusions (from your records)	20	101	246	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	309.90	89.06	28.07	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	6	18	47	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			3	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)	1,859	1,603	1,404	0	14.00
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)		22,099			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)		4,866			16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 15-1319 | Component CCN: 15-8553 | Period: From 10/01/2021 To 09/30/2022 | Worksheet M-4 | Date/Time Prepared: 2/23/2023 3:14 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)	627,580	627,580	627,580	627,580	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.004006	0.015927	0.000847	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	2,514	9,995	532	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	18,224	15,677	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	20,738	25,672	532	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	739,527	739,527	739,527	739,527	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	859,118	859,118	859,118	859,118	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.028042	0.034714	0.000719	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	24,091	29,823	618	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	44,829	55,495	1,150	0	10.00
11.00	Total number of injections/infusions (from your records)	123	489	26	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	364.46	113.49	44.23	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	17	138	7	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			2	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)	6,196	15,662	398	0	14.00
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)		101,474			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)		22,256			16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 15-1319 Component CCN: 15-8524	Period: From 10/01/2021 To 09/30/2022	Worksheet M-5 Date/Time Prepared: 2/23/2023 3:14 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		67,720	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)		67,720	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		9,676	6.02
7.00	Total Medicare program liability (see instructions)		58,044	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: 15-1319 Component CCN: 15-8553	Period: From 10/01/2021 To 09/30/2022	Worksheet M-5 Date/Time Prepared: 2/23/2023 3:14 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		240,345	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)		240,345	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		8,490	6.02
7.00	Total Medicare program liability (see instructions)		231,855	7.00

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