This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g).

FORM APPROVED
OMB NO. 0938-0050
EXPIRES 09-30-2025

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 15-1334	Period: From 01/01/2022 To 12/31/2022	Worksheet S Parts I-III Date/Time Prepared: 5/26/2023 9:37 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 5/26/2023 Time: 9:37 am
2. [ ] Manually prepared cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no.

Contractor use only

5. [1] Cost Report Status
   (1) As Submitted
   (2) Settled without Audit
   (3) Settled with Audit
   (4) Reopened
   (5) Amended
6. Date Received:
7. Contractor No.
8. [N] Initial Report for this Provider CCN
9. [N] Final Report for this Provider CCN
10. NPR Date:
11. Contractor's Vendor Code: 4
12. [0] If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION BY A CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OR PROVIDER(S)

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR Of PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by SCOTT MEMORIAL HOSPITAL (15-1334) for the cost reporting period beginning 01/01/2022 and ending 12/31/2022 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR		CHECKBOX	ELECTRONIC SIGNATURE STATEMENT	
	1		2		
1	Jason Schmiedt		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	Jason Schmiedt			2
3	Signatory Title	CHIEF FINANCIAL OFFICER			3
4	Date	(Dated when report is electronica			4

		Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	HOSPITAL	0	-133,696	-307,825	0	0	1.00
2.00	SUBPROVIDER - IPF	0	0	0		0	2.00
3.00	SUBPROVIDER - IRF	0	0	0		0	3.00
5.00	SWING BED - SNF	0	53,405	0		0	5.00
6.00	SWING BED - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		4,617		0	10.00
200.00	TOTAL	0	-80,291	-303,208	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1334 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-2 Part I | Date/Time Prepared: 5/26/2023 9:37 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1451 NORTH GARDNER	PO Box:			1.00
2.00	City: SCOTTSBURG	State: IN	Zip Code: 47170-	County: SCOTT	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	SCOTT MEMORIAL HOSPITAL	151334	99915	1	07/01/1966	N	O	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	SCOTT MEMORIAL SWING BEDS	15Z334	99915		03/21/2013	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC	SCOTTSBURG FAMILY PRACTICE	158523	99915		08/09/2017	N	O	O	15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2022	12/31/2022	20.00
21.00	Type of Control (see instructions)	4		21.00

		1.00	2.00	3.00	
	Inpatient PPS Information				
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N			22.00
22.01	Did this hospital receive interim UCPs, including supplemental UCPs, for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N		22.01
22.02	Is this a newly merged hospital that requires a final UCP to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or “N” for no.	N	N	N	22.03
22.04	Did this hospital receive a geographic reclassification from urban to rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.				22.04
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	0			23.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1334 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-2 Part I | Date/Time Prepared: 5/26/2023 9:37 am

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

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

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

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

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? For cost reporting periods beginning prior to December 27, 2020, enter "Y" for yes or "N" for no in column 1. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.78(b)(2), see the instructions. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2.	N			56.00
57.00	For cost reporting periods beginning prior to December 27, 2020, if line 56, column 1, is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.77(e)(1)(iv) and (v), regardless of which month(s) of the cost report the residents were on duty, if the response to line 56 is "Y" for yes, enter "Y" for yes in column 1, do not complete column 2, and complete Worksheet E-4.				57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	N			58.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1334	Period: From 01/01/2022 To 12/31/2022	Worksheet S-2 Part I Date/Time Prepared: 5/26/2023 9:37 am

		V	XVIII	XIX	
		1.00	2.00	3.00	
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1334 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-2 Part I Date/Time Prepared: 5/26/2023 9:37 am

				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: 15-1334	Period: From 01/01/2022 To 12/31/2022	Worksheet S-2 Part I Date/Time Prepared: 5/26/2023 9:37 am

		1.00	
	Direct GME in Accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022)		
68.00	For a cost reporting period beginning prior to October 1, 2022, did you obtain permission from your MAC to apply the new DGME formula in accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022)?	N	68.00

		1.00	2.00	3.00	
	Inpatient Psychiatric Facility PPS				
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N			70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	71.00
	Inpatient Rehabilitation Facility PPS				
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N			75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	76.00

		1.00	
	Long Term Care Hospital PPS		
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N	80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.	N	81.00
	TEFRA Providers		
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.		86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	N	87.00

		Approved for Permanent Adjustment (Y/N)	Number of Approved Permanent Adjustments	
		1.00	2.00	
88.00	Column 1: Is this hospital approved for a permanent adjustment to the TEFRA target amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete col. 2 and line 89. (see instructions) Column 2: Enter the number of approved permanent adjustments.		0	88.00

		Wkst. A Line No.	Effective Date	Approved Permanent Adjustment Amount Per Discharge	
		1.00	2.00	3.00	
89.00	Column 1: If line 88, column 1 is Y, enter the Worksheet A line number on which the per discharge permanent adjustment approval was based. Column 2: Enter the effective date (i.e., the cost reporting period beginning date) for the permanent adjustment to the TEFRA target amount per discharge. Column 3: Enter the amount of the approved permanent adjustment to the TEFRA target amount per discharge.	0.00		0	89.00

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	Y	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.	Y	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.		Y	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

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		V	XIX	
		1.00	2.00	
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.06
	Rural Providers			
105.00	Does this hospital qualify as a CAH?	Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	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 (PARHM) demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N			112.00
113.00	Did this hospital participate in the Community Health Access and Rural Transformation (CHART) model for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no.				113.00
	Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1334 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-2 Part I | Date/Time Prepared: 5/26/2023 9:37 am

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	86,229	0	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
123.00	Did the facility and/or its subproviders (if applicable) purchase professional services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, and/or management/consulting services, from an unrelated organization? In column 1, enter "Y" for yes or "N" for no. If column 1 is "Y", were the majority of the expenses, i.e., greater than 50% of total professional services expenses, for services purchased from unrelated organizations located in a CBSA outside of the main hospital CBSA? In column 2, enter "Y" for yes or "N" for no.			123.00
	Certified Transplant Center Information			
125.00	Does this facility operate a Medicare-certified transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare-certified kidney transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare-certified heart transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare-certified liver transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare-certified lung transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare-certified pancreas transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare-certified intestinal transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare-certified islet transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is a hospital-based organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	HB0616	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: LIFEPOINT HEALTH INC.	Contractor's Name: PALMETTO GBA	Contractor's Number: 10001	141.00
142.00	Street: PO BOX 100307	PO Box:		142.00
143.00	City: COLUMBIA	State: SC	Zip Code: 29202	143.00

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

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

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

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

			1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act			
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.		Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)			168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)			168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)		0.00	169.00
		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170.00
		1.00	2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N	0	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1334 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-2 Part II Date/Time Prepared: 5/26/2023 9:37 am

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

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

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	12/31/2022	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	05/02/2023	Y	05/02/2023	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1334 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-2 Part II Date/Time Prepared: 5/26/2023 9:37 am

		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.					33.00
	Provider-Based Physicians					
34.00	Were services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				N	35.00
				Y/N	Date	
				1.00	2.00	
	Home Office Costs					
36.00	Were home office costs claimed on the cost report?			Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			Y		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			N	12/31/2022	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.	DANA		AYLWARD		41.00
42.00	Enter the employer/company name of the cost report preparer.	LIFEPOINT HEALTH, INC.				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	203-260-7881		DANA.AYLWARD@LPNT.NET		43.00

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		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	REIMBURSEMENT 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: 15-1334 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-3 Part I | Date/Time Prepared: 5/26/2023 9:37 am

	Component	Worksheet A Line No.	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	21	7,665	37,804.78	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		21	7,665	37,804.78	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	4	1,460	1,691.17	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		25	9,125	39,495.95	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	88.00				0	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		25				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care	30.00	0	0		0	34.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1334 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-3 Part I | Date/Time Prepared: 5/26/2023 9:37 am

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	606	42	1,486			1.00
2.00	HMO and other (see instructions)	477	288				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	904	0	1,672			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		109	219			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,510	151	3,377			7.00
8.00	INTENSIVE CARE UNIT	35	3	87			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		0	0			13.00
14.00	Total (see instructions)	1,545	154	3,464	0.00	124.38	14.00
15.00	CAH visits	8,605	0	34,320			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	661	24	3,312	0.00	5.41	26.00
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	129.79	27.00
28.00	Observation Bed Days		30	622			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care	0	0	0			34.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1334 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-3 Part I | Date/Time Prepared: 5/26/2023 9:37 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	237	20	552	1.00
2.00	HMO and other (see instructions)			151	69		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	237	20	552	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0.00					26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care						34.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-1334 | Component CCN: 15-8523 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-8 | Date/Time Prepared: 5/26/2023 9:37 am

RHC I | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			1465 NORTH GARDNER STREET		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	SCOTTSBURG		IN	47170	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			08:30	17:00	08:30	11.00

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

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

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

			County				
			4.00				
2.00	City, State, ZIP Code, County		SCOTT				2.00
		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC	16:30	08:30	16:30	08:30	16:30	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-1334 | Component CCN: 15-8523 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-8 | Date/Time Prepared: 5/26/2023 9:37 am

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	08:30	16:30				11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-1334 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-10 | Date/Time Prepared: 5/26/2023 9:37 am

		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)	0.236067	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	4,696,244	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?	N	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	197,247	5.00
6.00	Medicaid charges	19,472,205	6.00
7.00	Medicaid cost (line 1 times line 6)	4,596,745	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)	0	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)	0	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)	948,599	0	948,599	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	223,933	0	223,933	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	223,933	0	223,933	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)	1,927,393	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	157,533	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	242,359	27.01
28.00	Non-Medicare bad debt expense (see instructions)	1,685,034	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	482,607	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	706,540	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	706,540	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1334 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A | Date/Time Prepared: 5/26/2023 9:37 am

		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		599,008	599,008	222,587	821,595	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		4,598	4,598	163,575	168,173	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	66,687	960,499	1,027,186	-21,612	1,005,574	4.00
5.01	00550	DATA PROCESSING	174,286	878,346	1,052,632	-127	1,052,505	5.01
5.02	00570	ADMITTING	490,693	185,923	676,616	-2,643	673,973	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	0	76,655	76,655	0	76,655	5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	390,783	390,783	0	390,783	5.04
5.05	00590	OTHER ADMIN AND GENERAL	817,439	2,844,179	3,661,618	-522,666	3,138,952	5.05
7.00	00700	OPERATION OF PLANT	224,257	653,693	877,950	-9,178	868,772	7.00
9.00	00900	HOUSEKEEPING	251,667	144,161	395,828	1,193	397,021	9.00
10.00	01000	DIETARY	189,008	188,248	377,256	-267,122	110,134	10.00
11.00	01100	CAFETERIA	0	0	0	266,893	266,893	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	229,339	229,339	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	66,055	-81,656	-15,601	-14,273	-29,874	14.00
15.00	01500	PHARMACY	179,522	467,717	647,239	-260,130	387,109	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	374,338	228,308	602,646	-3,871	598,775	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,659,808	501,829	2,161,637	-93,451	2,068,186	30.00
31.00	03100	INTENSIVE CARE UNIT	44,482	4,235	48,717	0	48,717	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	175,421	777,793	953,214	-67,696	885,518	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	842,012	720,106	1,562,118	-77,672	1,484,446	54.00
60.00	06000	LABORATORY	510,739	681,956	1,192,695	22,498	1,215,193	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	62,244	62,244	49,011	111,255	63.00
65.00	06500	RESPIRATORY THERAPY	428,061	131,990	560,051	-168,587	391,464	65.00
66.00	06600	PHYSICAL THERAPY	63,663	699,187	762,850	-10,689	752,161	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	19,445	19,445	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	607	607	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	154,831	154,831	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	91,957	91,957	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	12,593	12,593	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	350,273	350,273	73.00
76.00	03610	SLEEP LAB	15,703	4,750	20,453	0	20,453	76.00
76.97	07697	CARDIAC REHABILITATION	61,335	13,690	75,025	0	75,025	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	529,604	266,771	796,375	-79,505	716,870	88.00
91.00	09100	EMERGENCY	1,000,906	1,037,519	2,038,425	13,867	2,052,292	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		155,653	155,653	0	155,653	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	8,165,686	12,598,185	20,763,871	-553	20,763,318	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	MARKETING	24,856	133,501	158,357	0	158,357	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	-261	36,203	35,942	447	36,389	192.00
192.01	19201	SCOTT PHYSICIAN GROUP	0	0	0	0	0	192.01
194.00	07950	BUHSE CAMPUS	0	0	0	0	0	194.00
194.01	07951	MEDICAL SPECIALTY	59,506	126,191	185,697	106	185,803	194.01
194.02	07952	MEDICAL OFFICE	0	0	0	0	0	194.02
194.03	07953	VA PROPERTY	0	0	0	0	0	194.03
194.04	07954	ALREFAI CAMPUS	0	0	0	0	0	194.04
194.05	07955	ORTHO CAMPUS	501	7	508	0	508	194.05
194.06	07956	DR. CRAIG CLINIC	0	0	0	0	0	194.06
194.07	07957	DR. OLABIGE CLINIC	0	0	0	0	0	194.07
194.08	07958	URGENT CARE CLINIC	0	0	0	0	0	194.08
194.09	07959	DR. PACE	0	0	0	0	0	194.09
194.10	07960	SCOTTSBURG FAMILY PRACTICE (RHC)	0	0	0	0	0	194.10
200.00		TOTAL (SUM OF LINES 118 through 199)	8,250,288	12,894,087	21,144,375	0	21,144,375	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1334 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A | Date/Time Prepared: 5/26/2023 9:37 am

		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	-461,948	359,647		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	479,230	647,403		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	1,005,574		4.00
5.01	00550	DATA PROCESSING	0	1,052,505		5.01
5.02	00570	ADMITTING	0	673,973		5.02
5.03	00560	PURCHASING RECEIVING AND STORES	0	76,655		5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	390,783		5.04
5.05	00590	OTHER ADMIN AND GENERAL	-1,559,036	1,579,916		5.05
7.00	00700	OPERATION OF PLANT	-60	868,712		7.00
9.00	00900	HOUSEKEEPING	0	397,021		9.00
10.00	01000	DIETARY	0	110,134		10.00
11.00	01100	CAFETERIA	-82,411	184,482		11.00
13.00	01300	NURSING ADMINISTRATION	0	229,339		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-8,991	-38,865		14.00
15.00	01500	PHARMACY	-499	386,610		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-125	598,650		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-155,374	1,912,812		30.00
31.00	03100	INTENSIVE CARE UNIT	0	48,717		31.00
43.00	04300	NURSERY	0	0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-335,843	549,675		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-125,847	1,358,599		54.00
60.00	06000	LABORATORY	-27,600	1,187,593		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	111,255		63.00
65.00	06500	RESPIRATORY THERAPY	-5,063	386,401		65.00
66.00	06600	PHYSICAL THERAPY	0	752,161		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	19,445		67.00
68.00	06800	SPEECH PATHOLOGY	0	607		68.00
69.00	06900	ELECTROCARDIOLOGY	0	154,831		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	91,957		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	12,593		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	350,273		73.00
76.00	03610	SLEEP LAB	0	20,453		76.00
76.97	07697	CARDIAC REHABILITATION	0	75,025		76.97
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	716,870		88.00
91.00	09100	EMERGENCY	93	2,052,385		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	-155,653	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-2,439,127	18,324,191		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
190.01	19001	MARKETING	0	158,357		190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	36,389		192.00
192.01	19201	SCOTT PHYSICIAN GROUP	0	0		192.01
194.00	07950	BUHSE CAMPUS	0	0		194.00
194.01	07951	MEDICAL SPECIALTY	0	185,803		194.01
194.02	07952	MEDICAL OFFICE	0	0		194.02
194.03	07953	VA PROPERTY	0	0		194.03
194.04	07954	ALREFAI CAMPUS	0	0		194.04
194.05	07955	ORTHO CAMPUS	0	508		194.05
194.06	07956	DR. CRAIG CLINIC	0	0		194.06
194.07	07957	DR. OLABIGE CLINIC	0	0		194.07
194.08	07958	URGENT CARE CLINIC	0	0		194.08
194.09	07959	DR. PACE	0	0		194.09
194.10	07960	SCOTTSBURG FAMILY PRACTICE (RHC)	0	0		194.10
200.00		TOTAL (SUM OF LINES 118 through 199)	-2,439,127	18,705,248		200.00

RECLASSIFICATIONS | Provider CCN: 15-1334 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-6 | Date/Time Prepared: 5/26/2023 9:37 am

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - LEASES					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	77,090		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	122,601		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
	TOTALS		0	199,691		
	B - CNO					
1.00	NURSING ADMINISTRATION	13.00	196,329	14,165		1.00
	TOTALS		196,329	14,165		
	C - CORPORATE PAID BENEFITS					
1.00	NURSING ADMINISTRATION	13.00	0	18,845		1.00
	TOTALS		0	18,845		
	D - GENERAL LIABLILITY INSURANCE					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	40,974		1.00
	TOTALS		0	40,974		
	E - CAFETERIA					
1.00	CAFETERIA	11.00	133,715	133,178		1.00
	TOTALS		133,715	133,178		
	G - RESP THERAPY TO EKG					
1.00	ELECTROCARDIOLOGY	69.00	85,896	26,485		1.00
	TOTALS		85,896	26,485		
	H - MED SUPPLIES, DRUGS, COGS					
1.00	ADULTS & PEDIATRICS	30.00	0	743		1.00
2.00	LABORATORY	60.00	0	491		2.00
3.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	91,957		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
	TOTALS		0	93,191		
	I - COST TO CHARGE					
1.00	OPERATING ROOM	50.00	21,408	0		1.00
2.00	LABORATORY	60.00	15,563	8,036		2.00
3.00	BLOOD STORING, PROCESSING & TRANS.	63.00	38,641	10,370		3.00
4.00	OCCUPATIONAL THERAPY	67.00	8,671	10,774		4.00
5.00	SPEECH PATHOLOGY	68.00	274	333		5.00
6.00	ELECTROCARDIOLOGY	69.00	23,805	18,645		6.00
7.00	EMERGENCY	91.00	0	15,077		7.00
	TOTALS		108,362	63,235		
	J - PROPERTY TAX					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	145,497		1.00
	TOTALS		0	145,497		
	L - IMPLANTS RECLASS					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	12,593		1.00
2.00		0.00	0	0		2.00
	TOTALS		0	12,593		
	M - DRUGS RECLASS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	350,273		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
	TOTALS		0	350,273		
	O - COVID					
1.00	ADMITTING	5.02	2,334	0		1.00
2.00	DIETARY	10.00	284	0		2.00
3.00	MEDICAL RECORDS & LIBRARY	16.00	112	0		3.00
4.00	ADULTS & PEDIATRICS	30.00	8,144	0		4.00
5.00	LABORATORY	60.00	135	0		5.00
6.00	RESPIRATORY THERAPY	65.00	2,704	0		6.00

RECLASSIFICATIONS | Provider CCN: 15-1334 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-6 | Date/Time Prepared: 5/26/2023 9:37 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
7.00	EMERGENCY	91.00	3,235	0		7.00
8.00	MEDICAL SPECIALTY	194.01	106	0		8.00
9.00	OPERATION OF PLANT	7.00	378	0		9.00
10.00	HOUSEKEEPING	9.00	1,193	0		10.00
11.00	CENTRAL SERVICES & SUPPLY	14.00	610	0		11.00
12.00	RURAL HEALTH CLINIC	88.00	661	0		12.00
13.00	PHYSICIANS' PRIVATE OFFICES	192.00	447	0		13.00
	TOTALS		20,343	0		
500.00	Grand Total: Increases		544,645	1,098,127		500.00

RECLASSIFICATIONS | Provider CCN: 15-1334 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-6 | Date/Time Prepared: 5/26/2023 9:37 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - LEASES						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	2,767	10		1.00
2.00	DATA PROCESSING	5.01	0	127	10		2.00
3.00	ADMITTING	5.02	0	4,977	0		3.00
4.00	OTHER ADMIN AND GENERAL	5.05	0	15,588	0		4.00
5.00	OPERATION OF PLANT	7.00	0	9,556	0		5.00
6.00	DIETARY	10.00	0	513	0		6.00
7.00	CENTRAL SERVICES & SUPPLY	14.00	0	513	0		7.00
8.00	PHARMACY	15.00	0	513	0		8.00
9.00	MEDICAL RECORDS & LIBRARY	16.00	0	3,983	0		9.00
10.00	ADULTS & PEDIATRICS	30.00	0	6,448	0		10.00
11.00	OPERATING ROOM	50.00	0	55,211	0		11.00
12.00	RADIOLOGY-DIAGNOSTIC	54.00	0	2,471	0		12.00
13.00	LABORATORY	60.00	0	1,400	0		13.00
14.00	RESPIRATORY THERAPY	65.00	0	10,757	0		14.00
15.00	PHYSICAL THERAPY	66.00	0	1,527	0		15.00
16.00	RURAL HEALTH CLINIC	88.00	0	80,166	0		16.00
17.00	EMERGENCY	91.00	0	3,174	0		17.00
	TOTALS		0	199,691			
	B - CNO						
1.00	OTHER ADMIN AND GENERAL	5.05	196,329	14,165	0		1.00
	TOTALS		196,329	14,165			
	C - CORPORATE PAID BENEFITS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	18,845	0		1.00
	TOTALS		0	18,845			
	D - GENERAL LIABLILITY INSURANCE						
1.00	OTHER ADMIN AND GENERAL	5.05	0	40,974	12		1.00
	TOTALS		0	40,974			
	E - CAFETERIA						
1.00	DIETARY	10.00	133,715	133,178	0		1.00
	TOTALS		133,715	133,178			
	G - RESP THERAPY TO EKG						
1.00	RESPIRATORY THERAPY	65.00	85,896	26,485	0		1.00
	TOTALS		85,896	26,485			
	H - MED SUPPLIES, DRUGS, COGS						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	8,693	0		1.00
2.00	OPERATING ROOM	50.00	0	18,328	0		2.00
3.00	RADIOLOGY-DIAGNOSTIC	54.00	0	32,734	0		3.00
4.00	RESPIRATORY THERAPY	65.00	0	32,742	0		4.00
5.00	PHYSICAL THERAPY	66.00	0	694	0		5.00
	TOTALS		0	93,191			
	I - COST TO CHARGE						
1.00	ADULTS & PEDIATRICS	30.00	70,955	24,769	0		1.00
2.00	OPERATING ROOM	50.00	0	8,256	0		2.00
3.00	RADIOLOGY-DIAGNOSTIC	54.00	23,815	18,652	0		3.00
4.00	RESPIRATORY THERAPY	65.00	12,046	3,365	0		4.00
5.00	PHYSICAL THERAPY	66.00	275	8,193	0		5.00
6.00	EMERGENCY	91.00	1,271	0	0		6.00
7.00		0.00	0	0	0		7.00
	TOTALS		108,362	63,235			
	J - PROPERTY TAX						
1.00	OTHER ADMIN AND GENERAL	5.05	0	145,497	13		1.00
	TOTALS		0	145,497			
	L - IMPLANTS RECLASS						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	5,677	0		1.00
2.00	OPERATING ROOM	50.00	0	6,916	0		2.00
	TOTALS		0	12,593			
	M - DRUGS RECLASS						
1.00	OTHER ADMIN AND GENERAL	5.05	0	89,770	0		1.00
2.00	PHARMACY	15.00	0	259,617	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	166	0		3.00
4.00	OPERATING ROOM	50.00	0	393	0		4.00
5.00	LABORATORY	60.00	0	327	0		5.00
	TOTALS		0	350,273			
	O - COVID						
1.00	OTHER ADMIN AND GENERAL	5.05	20,343	0	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00

RECLASSIFICATIONS | Provider CCN: 15-1334 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-6 | Date/Time Prepared: 5/26/2023 9:37 am

	Decreases							
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.			
	6.00	7.00	8.00	9.00	10.00			
10.00		0.00	0	0	0			10.00
11.00		0.00	0	0	0			11.00
12.00		0.00	0	0	0			12.00
13.00		0.00	0	0	0			13.00
	TOTALS		20,343	0				
500.00	Grand Total: Decreases		544,645	1,098,127				500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1334 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-7 Part I | Date/Time Prepared: 5/26/2023 9:37 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	840,000	0	0	0	0	1.00
2.00	Land Improvements	444,683	0	0	0	0	2.00
3.00	Buildings and Fixtures	3,056,164	0	0	0	0	3.00
4.00	Building Improvements	504,831	157,420	0	157,420	0	4.00
5.00	Fixed Equipment	1,822,767	348,825	0	348,825	0	5.00
6.00	Movable Equipment	4,542,418	160,540	0	160,540	63,200	6.00
7.00	HIT designated Assets	1,345,381	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	12,556,244	666,785	0	666,785	63,200	8.00
9.00	Reconciling Items	6,576,480	58,658	0	58,658	0	9.00
10.00	Total (line 8 minus line 9)	5,979,764	608,127	0	608,127	63,200	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	840,000	0	1.00
2.00	Land Improvements	444,683	0	2.00
3.00	Buildings and Fixtures	3,056,164	0	3.00
4.00	Building Improvements	662,251	0	4.00
5.00	Fixed Equipment	2,171,592	0	5.00
6.00	Movable Equipment	4,639,758	0	6.00
7.00	HIT designated Assets	1,345,381	0	7.00
8.00	Subtotal (sum of lines 1-7)	13,159,829	0	8.00
9.00	Reconciling Items	6,635,138	0	9.00
10.00	Total (line 8 minus line 9)	6,524,691	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1334 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-7 Part II | Date/Time Prepared: 5/26/2023 9:37 am

	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	599,008	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	4,598	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	603,606	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL			
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)		
		14.00	15.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2				
1.00	CAP REL COSTS-BLDG & FIXT	0	599,008		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	4,598		2.00
3.00	Total (sum of lines 1-2)	0	603,606		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1334 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-7 Part III Date/Time Prepared: 5/26/2023 9:37 am

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	3,557,237	0	3,557,237	0.545196	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2,967,454	0	2,967,454	0.454804	0	2.00
3.00	Total (sum of lines 1-2)	6,524,691	0	6,524,691	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	137,060	77,090	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	483,828	122,601	2.00
3.00	Total (sum of lines 1-2)	0	0	0	620,888	199,691	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	145,497	0	359,647	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	40,974	0	0	647,403	2.00
3.00	Total (sum of lines 1-2)	0	40,974	145,497	0	1,007,050	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1334 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-8 | Date/Time Prepared: 5/26/2023 9:37 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-649,764			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	-475,812			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-82,411	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	-125	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines	B	-736	OTHER ADMIN AND GENERAL	5.05	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	A	-461,948	CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	A	479,230	CAP REL COSTS-MVBLE EQUIP	2.00	9	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
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	-1,224	OTHER ADMIN AND GENERAL	5.05	0	33.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1334 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-8 | Date/Time Prepared: 5/26/2023 9:37 am

	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	
33.01	INDIANA PROVIDER TAX	A	-1,125,084	OTHER ADMIN AND GENERAL	5.05	0	33.01
33.03	PHYSICIAN RECRUITING	A	-60,208	OTHER ADMIN AND GENERAL	5.05	9	33.03
34.00	LEGAL EXPENSES	A	-49,495	OTHER ADMIN AND GENERAL	5.05	0	34.00
34.01	LOST CHARGES	A	-544	CENTRAL SERVICES & SUPPLY	14.00	0	34.01
36.00	LOST CHARGES	A	37	ADULTS & PEDIATRICS	30.00	0	36.00
37.00	LOST CHARGES	A	93	EMERGENCY	91.00	0	37.00
37.01	SERVICES TO NON PATIENTS	A	0	DIETARY	10.00	0	37.01
37.02	LOBBYING	A	-1,929	OTHER ADMIN AND GENERAL	5.05	0	37.02
37.03	OPERATION OF PLANT ADVERTISING	A	-60	OPERATION OF PLANT	7.00	0	37.03
37.04	CENTRAL SERVICE & SUPPLY ADVERTISING	A	-1,398	CENTRAL SERVICES & SUPPLY	14.00	0	37.04
37.05	PHARMACY ADVERTISING	A	-499	PHARMACY	15.00	0	37.05
37.06	OTHER	A	-6,250	OTHER ADMIN AND GENERAL	5.05	0	37.06
37.07	LOBBYING	A	-1,000	OTHER ADMIN AND GENERAL	5.05	0	37.07
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-2,439,127				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: 15-1334 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-8-1 | Date/Time Prepared: 5/26/2023 9:37 am

	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	113.00	INTEREST EXPENSE	HOME OFFICE INTEREST	0	155,653	1.00
2.00	5.05	OTHER ADMIN AND GENERAL	HOME OFFICE MANAGEMENT	430,086	675,199	2.00
3.00	5.05	OTHER ADMIN AND GENERAL	C SUITE PAYROLL TAXES	-11,954	0	3.00
4.00	14.00	CENTRAL SERVICES & SUPPLY	HPG PURCHASING	7,338	14,387	4.00
4.01	5.05	OTHER ADMIN AND GENERAL	MALPRACTICE	20,815	76,858	4.01
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			446,285	922,097	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	B		0.00	LIFEPOINT HOSP	100.00	6.00
7.00			0.00	HPG	0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					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: 15-1334	Period: From 01/01/2022 To 12/31/2022	Worksheet A-8-1 Date/Time Prepared: 5/26/2023 9:37 am

	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	-155,653	0		1.00
2.00	-245,113	0		2.00
3.00	-11,954	0		3.00
4.00	-7,049	0		4.00
4.01	-56,043	0		4.01
5.00	-475,812			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	HOSP MANAGEMENT		6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-1334 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-8-2 | Date/Time Prepared: 5/26/2023 9:37 am

	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	50.00	DR. A	12,145	12,145	0	0	0	1.00
2.00	50.00	DR. B	347,262	323,698	23,564	0	0	2.00
3.00	54.00	DR. C	24,990	24,990	0	0	0	3.00
4.00	54.00	DR. D	8,750	8,750	0	0	0	4.00
5.00	54.00	DR. E	71,274	71,274	0	0	0	5.00
6.00	54.00	DR. F	20,833	20,833	0	0	0	6.00
7.00	60.00	AGGREGATE-LABORATORY	27,600	27,600	0	0	0	7.00
8.00	65.00	AGGREGATE-RESPIRATORY THERAPY	5,063	5,063	0	0	0	8.00
9.00	91.00	AGGREGATE-EMERGENCY	288,350	0	288,350	0	0	9.00
10.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	155,411	155,411	0	0	0	10.00
200.00			961,678	649,764	311,914		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	50.00	DR. A	0	0	0	0	0	1.00
2.00	50.00	DR. B	0	0	0	0	0	2.00
3.00	54.00	DR. C	0	0	0	0	0	3.00
4.00	54.00	DR. D	0	0	0	0	0	4.00
5.00	54.00	DR. E	0	0	0	0	0	5.00
6.00	54.00	DR. F	0	0	0	0	0	6.00
7.00	60.00	AGGREGATE-LABORATORY	0	0	0	0	0	7.00
8.00	65.00	AGGREGATE-RESPIRATORY THERAPY	0	0	0	0	0	8.00
9.00	91.00	AGGREGATE-EMERGENCY	0	0	0	0	0	9.00
10.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	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	50.00	DR. A	0	0	0	12,145		1.00
2.00	50.00	DR. B	0	0	0	323,698		2.00
3.00	54.00	DR. C	0	0	0	24,990		3.00
4.00	54.00	DR. D	0	0	0	8,750		4.00
5.00	54.00	DR. E	0	0	0	71,274		5.00
6.00	54.00	DR. F	0	0	0	20,833		6.00
7.00	60.00	AGGREGATE-LABORATORY	0	0	0	27,600		7.00
8.00	65.00	AGGREGATE-RESPIRATORY THERAPY	0	0	0	5,063		8.00
9.00	91.00	AGGREGATE-EMERGENCY	0	0	0	0		9.00
10.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	0	0	0	155,411		10.00
200.00			0	0	0	649,764		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 15-1334 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-8-3 Parts I-VI Date/Time Prepared: 5/26/2023 9:37 am

Physical Therapy | Cost

						1.00	
	PART I - GENERAL INFORMATION						
1.00	Total number of weeks worked (excluding aides) (see instructions)					0	1.00
2.00	Line 1 multiplied by 15 hours per week					0	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					0	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					0.00	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	7,064.96	0.00	3,824.62	0.00	9.00
10.00	AHSEA (see instructions)	74.74	82.61	27.64	41.45	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)	41.31	41.31	13.82			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)					583,636	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)					0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					583,636	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					158,530	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)					742,166	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)					742,166	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)					0	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)					0	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)					0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					0	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: 15-1334 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 5/26/2023 9:37 am

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)	82.61	27.64	41.45	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)	742,166		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)	742,166		63.00
64.00	Total cost of outside supplier services (from your records)	655,690		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	0		100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	0		100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	0		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	0		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	0		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: 15-1334 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part I | Date/Time Prepared: 5/26/2023 9:37 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	DATA PROCESSING	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	5.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	359,647	359,647				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	647,403		647,403			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,005,574	0	0	1,005,574		4.00
5.01	00550	DATA PROCESSING	1,052,505	2,221	4,942	21,416	1,081,084	5.01
5.02	00570	ADMITTING	673,973	10,132	22,541	60,582	80,771	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	76,655	6,035	13,427	0	0	5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	390,783	1,961	4,363	0	0	5.04
5.05	00590	OTHER ADMIN AND GENERAL	1,579,916	46,886	104,310	73,820	86,984	5.05
7.00	00700	OPERATION OF PLANT	868,712	11,915	26,509	27,602	24,853	7.00
9.00	00900	HOUSEKEEPING	397,021	2,493	5,546	31,071	6,213	9.00
10.00	01000	DIETARY	110,134	7,199	16,015	6,829	18,639	10.00
11.00	01100	CAFETERIA	184,482	3,673	8,171	16,430	0	11.00
13.00	01300	NURSING ADMINISTRATION	229,339	0	0	24,124	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-38,865	0	0	8,192	43,492	14.00
15.00	01500	PHARMACY	386,610	0	0	22,059	55,918	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	598,650	4,767	10,605	46,011	68,344	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,912,812	41,624	92,602	196,231	118,050	30.00
31.00	03100	INTENSIVE CARE UNIT	48,717	2,199	4,893	5,466	0	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	549,675	59,135	131,564	24,186	99,410	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,358,599	15,619	34,747	100,538	105,623	54.00
60.00	06000	LABORATORY	1,187,593	6,791	15,109	64,687	55,918	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	111,255	0	0	4,748	0	63.00
65.00	06500	RESPIRATORY THERAPY	386,401	9,403	20,920	40,896	0	65.00
66.00	06600	PHYSICAL THERAPY	752,161	9,550	21,247	7,789	55,918	66.00
67.00	06700	OCCUPATIONAL THERAPY	19,445	0	0	1,065	0	67.00
68.00	06800	SPEECH PATHOLOGY	607	0	0	34	0	68.00
69.00	06900	ELECTROCARDIOLOGY	154,831	0	0	13,480	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	91,957	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	12,593	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	350,273	1,875	4,172	0	0	73.00
76.00	03610	SLEEP LAB	20,453	0	0	1,930	0	76.00
76.97	07697	CARDIAC REHABILITATION	75,025	3,216	7,154	7,537	62,131	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	716,870	9,971	22,183	65,157	93,197	88.00
91.00	09100	EMERGENCY	2,052,385	19,953	44,391	123,230	86,984	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	18,324,191	276,618	615,411	995,110	1,062,445	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1,870	4,159	0	0	190.00
190.01	19001	MARKETING	158,357	0	0	3,054	0	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	36,389	0	0	23	18,639	192.00
192.01	19201	SCOTT PHYSICIAN GROUP	0	0	0	0	0	192.01
194.00	07950	BUHSE CAMPUS	0	6,249	13,901	0	0	194.00
194.01	07951	MEDICAL SPECIALTY	185,803	6,262	13,932	7,325	0	194.01
194.02	07952	MEDICAL OFFICE	0	40,951	0	0	0	194.02
194.03	07953	VA PROPERTY	0	27,697	0	0	0	194.03
194.04	07954	ALREFAI CAMPUS	0	0	0	0	0	194.04
194.05	07955	ORTHO CAMPUS	508	0	0	62	0	194.05
194.06	07956	DR. CRAIG CLINIC	0	0	0	0	0	194.06
194.07	07957	DR. OLABIGE CLINIC	0	0	0	0	0	194.07
194.08	07958	URGENT CARE CLINIC	0	0	0	0	0	194.08
194.09	07959	DR. PACE	0	0	0	0	0	194.09
194.10	07960	SCOTTSBURG FAMILY PRACTICE (RHC)	0	0	0	0	0	194.10
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers			0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	18,705,248	359,647	647,403	1,005,574	1,081,084	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1334 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part I | Date/Time Prepared: 5/26/2023 9:37 am

		Cost Center Description	ADMITTING	PURCHASING RECEIVING AND STORES	CASHIERING/ACCOUNTS RECEIVABLE	Subtotal	OTHER ADMIN AND GENERAL	
			5.02	5.03	5.04	5A.04	5.05	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	DATA PROCESSING						5.01
5.02	00570	ADMITTING	847,999					5.02
5.03	00560	PURCHASING RECEIVING AND STORES	0	96,117				5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0	397,107			5.04
5.05	00590	OTHER ADMIN AND GENERAL	0	11,201	0	1,903,117	1,903,117	5.05
7.00	00700	OPERATION OF PLANT	0	1,211	0	960,802	108,830	7.00
9.00	00900	HOUSEKEEPING	0	1,664	0	444,008	50,293	9.00
10.00	01000	DIETARY	0	5,782	0	164,598	18,644	10.00
11.00	01100	CAFETERIA	0	0	0	212,756	24,099	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	253,463	28,710	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,066	0	13,885	1,573	14.00
15.00	01500	PHARMACY	0	19,708	0	484,295	54,856	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	102	0	728,479	82,515	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	129,446	6,790	12,686	2,510,241	284,338	30.00
31.00	03100	INTENSIVE CARE UNIT	7,804	0	657	69,736	7,899	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,739	2,961	4,937	877,607	99,407	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	58,995	2,203	97,086	1,773,410	200,874	54.00
60.00	06000	LABORATORY	135,437	18,929	91,671	1,576,135	178,529	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	6,457	3,415	1,421	127,296	14,419	63.00
65.00	06500	RESPIRATORY THERAPY	67,275	1,312	17,567	543,774	61,593	65.00
66.00	06600	PHYSICAL THERAPY	52,717	373	19,629	919,384	104,139	66.00
67.00	06700	OCCUPATIONAL THERAPY	24,543	0	3,064	48,117	5,450	67.00
68.00	06800	SPEECH PATHOLOGY	438	0	92	1,171	133	68.00
69.00	06900	ELECTROCARDIOLOGY	11,929	0	10,128	190,368	21,563	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	121,252	5,051	12,978	231,238	26,192	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	575	691	67	13,926	1,577	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	177,870	0	49,586	583,776	66,124	73.00
76.00	03610	SLEEP LAB	137	37	1,018	23,575	2,670	76.00
76.97	07697	CARDIAC REHABILITATION	0	103	1,693	156,859	17,767	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	2,779	6,278	916,435	103,805	88.00
91.00	09100	EMERGENCY	47,385	10,628	66,549	2,451,505	277,682	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	847,999	96,006	397,107	18,179,956	1,843,681	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	6,029	683	190.00
190.01	19001	MARKETING	0	0	0	161,411	18,283	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	55,051	6,236	192.00
192.01	19201	SCOTT PHYSICIAN GROUP	0	0	0	0	0	192.01
194.00	07950	BUHSE CAMPUS	0	0	0	20,150	2,282	194.00
194.01	07951	MEDICAL SPECIALTY	0	111	0	213,433	24,176	194.01
194.02	07952	MEDICAL OFFICE	0	0	0	40,951	4,639	194.02
194.03	07953	VA PROPERTY	0	0	0	27,697	3,137	194.03
194.04	07954	ALREFAI CAMPUS	0	0	0	0	0	194.04
194.05	07955	ORTHO CAMPUS	0	0	0	570	0	194.05
194.06	07956	DR. CRAIG CLINIC	0	0	0	0	0	194.06
194.07	07957	DR. OLABIGE CLINIC	0	0	0	0	0	194.07
194.08	07958	URGENT CARE CLINIC	0	0	0	0	0	194.08
194.09	07959	DR. PACE	0	0	0	0	0	194.09
194.10	07960	SCOTTSBURG FAMILY PRACTICE (RHC)	0	0	0	0	0	194.10
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)	847,999	96,117	397,107	18,705,248	1,903,117	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1334 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part I | Date/Time Prepared: 5/26/2023 9:37 am

		Cost Center Description	OPERATION OF PLANT	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
			7.00	9.00	10.00	11.00	13.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	DATA PROCESSING						5.01
5.02	00570	ADMITTING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05	00590	OTHER ADMIN AND GENERAL						5.05
7.00	00700	OPERATION OF PLANT	1,069,632					7.00
9.00	00900	HOUSEKEEPING	9,506	503,807				9.00
10.00	01000	DIETARY	27,451	0	210,693			10.00
11.00	01100	CAFETERIA	14,005	6,472	0	257,332		11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	3,145	285,318	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	4,046	0	14.00
15.00	01500	PHARMACY	0	0	0	6,779	6,859	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	18,177	13,626	0	17,667	60,904	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	158,725	131,487	198,323	61,062	76,542	30.00
31.00	03100	INTENSIVE CARE UNIT	8,386	19,076	4,134	1,607	5,761	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	225,509	95,379	0	9,736	44,855	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	59,559	23,164	0	31,228	0	54.00
60.00	06000	LABORATORY	25,898	38,152	0	32,329	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	1,745	0	63.00
65.00	06500	RESPIRATORY THERAPY	35,858	19,076	0	16,088	5,624	65.00
66.00	06600	PHYSICAL THERAPY	36,418	27,251	0	15,805	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	3,697	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	10,900	0	4,518	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	7,150	6,813	0	0	0	73.00
76.00	03610	SLEEP LAB	0	0	0	665	0	76.00
76.97	07697	CARDIAC REHABILITATION	12,262	6,813	0	2,829	6,859	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	38,023	0	0	0	0	88.00
91.00	09100	EMERGENCY	76,088	105,598	8,236	43,494	77,914	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	753,015	503,807	210,693	256,440	285,318	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	7,129	0	0	0	0	190.00
190.01	19001	MARKETING	0	0	0	892	0	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	SCOTT PHYSICIAN GROUP	0	0	0	0	0	192.01
194.00	07950	BUHSE CAMPUS	23,828	0	0	0	0	194.00
194.01	07951	MEDICAL SPECIALTY	23,881	0	0	0	0	194.01
194.02	07952	MEDICAL OFFICE	156,159	0	0	0	0	194.02
194.03	07953	VA PROPERTY	105,620	0	0	0	0	194.03
194.04	07954	ALREFAI CAMPUS	0	0	0	0	0	194.04
194.05	07955	ORTHO CAMPUS	0	0	0	0	0	194.05
194.06	07956	DR. CRAIG CLINIC	0	0	0	0	0	194.06
194.07	07957	DR. OLABIGE CLINIC	0	0	0	0	0	194.07
194.08	07958	URGENT CARE CLINIC	0	0	0	0	0	194.08
194.09	07959	DR. PACE	0	0	0	0	0	194.09
194.10	07960	SCOTTSBURG FAMILY PRACTICE (RHC)	0	0	0	0	0	194.10
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)	1,069,632	503,807	210,693	257,332	285,318	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1334 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part I Date/Time Prepared: 5/26/2023 9:37 am

		Cost Center Description	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			14.00	15.00	16.00	24.00	25.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	DATA PROCESSING						5.01
5.02	00570	ADMITTING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05	00590	OTHER ADMIN AND GENERAL						5.05
7.00	00700	OPERATION OF PLANT						7.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	19,504					14.00
15.00	01500	PHARMACY	5,113	557,902				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	26	0	921,394			16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,761	0	29,434	3,451,913	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	1,525	118,124	0	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	768	0	11,455	1,364,716	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	571	0	225,293	2,314,099	0	54.00
60.00	06000	LABORATORY	4,910	0	212,693	2,068,646	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	886	0	3,298	147,644	0	63.00
65.00	06500	RESPIRATORY THERAPY	340	0	40,759	723,112	0	65.00
66.00	06600	PHYSICAL THERAPY	97	0	45,543	1,148,637	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	7,109	64,373	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	212	1,516	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	23,498	250,847	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,309	0	30,110	288,849	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	179	0	156	15,838	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	557,902	115,047	1,336,812	0	73.00
76.00	03610	SLEEP LAB	10	0	2,361	29,281	0	76.00
76.97	07697	CARDIAC REHABILITATION	27	0	3,928	207,344	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	721	0	14,567	1,073,551	0	88.00
91.00	09100	EMERGENCY	2,757	0	154,406	3,197,680	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	19,475	557,902	921,394	17,802,982	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	13,841	0	190.00
190.01	19001	MARKETING	0	0	0	180,586	0	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	61,287	0	192.00
192.01	19201	SCOTT PHYSICIAN GROUP	0	0	0	0	0	192.01
194.00	07950	BUHSE CAMPUS	0	0	0	46,260	0	194.00
194.01	07951	MEDICAL SPECIALTY	29	0	0	261,519	0	194.01
194.02	07952	MEDICAL OFFICE	0	0	0	201,749	0	194.02
194.03	07953	VA PROPERTY	0	0	0	136,454	0	194.03
194.04	07954	ALREFAI CAMPUS	0	0	0	0	0	194.04
194.05	07955	ORTHO CAMPUS	0	0	0	570	0	194.05
194.06	07956	DR. CRAIG CLINIC	0	0	0	0	0	194.06
194.07	07957	DR. OLABIGE CLINIC	0	0	0	0	0	194.07
194.08	07958	URGENT CARE CLINIC	0	0	0	0	0	194.08
194.09	07959	DR. PACE	0	0	0	0	0	194.09
194.10	07960	SCOTTSBURG FAMILY PRACTICE (RHC)	0	0	0	0	0	194.10
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	19,504	557,902	921,394	18,705,248	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1334 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part I | Date/Time Prepared: 5/26/2023 9:37 am

		Cost Center Description	Total		
			26.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.01	00550	DATA PROCESSING			5.01
5.02	00570	ADMITTING			5.02
5.03	00560	PURCHASING RECEIVING AND STORES			5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE			5.04
5.05	00590	OTHER ADMIN AND GENERAL			5.05
7.00	00700	OPERATION OF PLANT			7.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	3,451,913		30.00
31.00	03100	INTENSIVE CARE UNIT	118,124		31.00
43.00	04300	NURSERY	0		43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	1,364,716		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,314,099		54.00
60.00	06000	LABORATORY	2,068,646		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	147,644		63.00
65.00	06500	RESPIRATORY THERAPY	723,112		65.00
66.00	06600	PHYSICAL THERAPY	1,148,637		66.00
67.00	06700	OCCUPATIONAL THERAPY	64,373		67.00
68.00	06800	SPEECH PATHOLOGY	1,516		68.00
69.00	06900	ELECTROCARDIOLOGY	250,847		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	288,849		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	15,838		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,336,812		73.00
76.00	03610	SLEEP LAB	29,281		76.00
76.97	07697	CARDIAC REHABILITATION	207,344		76.97
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	1,073,551		88.00
91.00	09100	EMERGENCY	3,197,680		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	17,802,982		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	13,841		190.00
190.01	19001	MARKETING	180,586		190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	61,287		192.00
192.01	19201	SCOTT PHYSICIAN GROUP	0		192.01
194.00	07950	BUHSE CAMPUS	46,260		194.00
194.01	07951	MEDICAL SPECIALTY	261,519		194.01
194.02	07952	MEDICAL OFFICE	201,749		194.02
194.03	07953	VA PROPERTY	136,454		194.03
194.04	07954	ALREFAI CAMPUS	0		194.04
194.05	07955	ORTHO CAMPUS	570		194.05
194.06	07956	DR. CRAIG CLINIC	0		194.06
194.07	07957	DR. OLABIGE CLINIC	0		194.07
194.08	07958	URGENT CARE CLINIC	0		194.08
194.09	07959	DR. PACE	0		194.09
194.10	07960	SCOTTSBURG FAMILY PRACTICE (RHC)	0		194.10
200.00		Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118 through 201)	18,705,248		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1334 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part II Date/Time Prepared: 5/26/2023 9:37 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.01	00550	DATA PROCESSING	0	2,221	4,942	7,163	0	5.01
5.02	00570	ADMITTING	0	10,132	22,541	32,673	0	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	108,686	6,035	13,427	128,148	0	5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	1,961	4,363	6,324	0	5.04
5.05	00590	OTHER ADMIN AND GENERAL	0	46,886	104,310	151,196	0	5.05
7.00	00700	OPERATION OF PLANT	0	11,915	26,509	38,424	0	7.00
9.00	00900	HOUSEKEEPING	0	2,493	5,546	8,039	0	9.00
10.00	01000	DIETARY	0	7,199	16,015	23,214	0	10.00
11.00	01100	CAFETERIA	0	3,673	8,171	11,844	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	4,767	10,605	15,372	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	41,624	92,602	134,226	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	2,199	4,893	7,092	0	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	59,135	131,564	190,699	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	15,619	34,747	50,366	0	54.00
60.00	06000	LABORATORY	0	6,791	15,109	21,900	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	9,403	20,920	30,323	0	65.00
66.00	06600	PHYSICAL THERAPY	0	9,550	21,247	30,797	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	6,851	0	0	6,851	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	1,875	4,172	6,047	0	73.00
76.00	03610	SLEEP LAB	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	3,216	7,154	10,370	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	9,971	22,183	32,154	0	88.00
91.00	09100	EMERGENCY	0	19,953	44,391	64,344	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	115,537	276,618	615,411	1,007,566	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1,870	4,159	6,029	0	190.00
190.01	19001	MARKETING	0	0	0	0	0	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	SCOTT PHYSICIAN GROUP	0	0	0	0	0	192.01
194.00	07950	BUHSE CAMPUS	0	6,249	13,901	20,150	0	194.00
194.01	07951	MEDICAL SPECIALTY	0	6,262	13,932	20,194	0	194.01
194.02	07952	MEDICAL OFFICE	0	40,951	0	40,951	0	194.02
194.03	07953	VA PROPERTY	0	27,697	0	27,697	0	194.03
194.04	07954	ALREFAI CAMPUS	0	0	0	0	0	194.04
194.05	07955	ORTHO CAMPUS	0	0	0	0	0	194.05
194.06	07956	DR. CRAIG CLINIC	0	0	0	0	0	194.06
194.07	07957	DR. OLABIGE CLINIC	0	0	0	0	0	194.07
194.08	07958	URGENT CARE CLINIC	0	0	0	0	0	194.08
194.09	07959	DR. PACE	0	0	0	0	0	194.09
194.10	07960	SCOTTSBURG FAMILY PRACTICE (RHC)	0	0	0	0	0	194.10
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)	115,537	359,647	647,403	1,122,587	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1334 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part II Date/Time Prepared: 5/26/2023 9:37 am

		Cost Center Description	DATA PROCESSING	ADMITTING	PURCHASING RECEIVING AND STORES	CASHIERING/ACCOUNTS RECEIVABLE	OTHER ADMIN AND GENERAL	
			5.01	5.02	5.03	5.04	5.05	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	DATA PROCESSING	7,163					5.01
5.02	00570	ADMITTING	535	33,208				5.02
5.03	00560	PURCHASING RECEIVING AND STORES	0	0	128,148			5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0	0	6,324		5.04
5.05	00590	OTHER ADMIN AND GENERAL	576	0	14,934	0	166,706	5.05
7.00	00700	OPERATION OF PLANT	165	0	1,614	0	9,533	7.00
9.00	00900	HOUSEKEEPING	41	0	2,218	0	4,405	9.00
10.00	01000	DIETARY	124	0	7,709	0	1,633	10.00
11.00	01100	CAFETERIA	0	0	0	0	2,111	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	2,515	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	288	0	1,421	0	138	14.00
15.00	01500	PHARMACY	371	0	26,276	0	4,805	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	453	0	136	0	7,228	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	779	5,069	9,053	202	24,908	30.00
31.00	03100	INTENSIVE CARE UNIT	0	306	0	10	692	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	659	225	3,948	79	8,708	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	700	2,310	2,937	1,539	17,596	54.00
60.00	06000	LABORATORY	371	5,303	25,237	1,462	15,638	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	253	4,553	23	1,263	63.00
65.00	06500	RESPIRATORY THERAPY	0	2,634	1,750	280	5,395	65.00
66.00	06600	PHYSICAL THERAPY	371	2,064	497	313	9,122	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	961	0	49	477	67.00
68.00	06800	SPEECH PATHOLOGY	0	17	0	1	12	68.00
69.00	06900	ELECTROCARDIOLOGY	0	467	0	162	1,889	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	4,748	6,734	207	2,294	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	23	921	1	138	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	6,968	0	791	5,792	73.00
76.00	03610	SLEEP LAB	0	5	49	16	234	76.00
76.97	07697	CARDIAC REHABILITATION	412	0	137	27	1,556	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	618	0	3,706	100	9,093	88.00
91.00	09100	EMERGENCY	576	1,855	14,170	1,062	24,324	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	7,039	33,208	128,000	6,324	161,499	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	60	190.00
190.01	19001	MARKETING	0	0	0	0	1,602	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	124	0	0	0	546	192.00
192.01	19201	SCOTT PHYSICIAN GROUP	0	0	0	0	0	192.01
194.00	07950	BUHSE CAMPUS	0	0	0	0	200	194.00
194.01	07951	MEDICAL SPECIALTY	0	0	148	0	2,118	194.01
194.02	07952	MEDICAL OFFICE	0	0	0	0	406	194.02
194.03	07953	VA PROPERTY	0	0	0	0	275	194.03
194.04	07954	ALREFAI CAMPUS	0	0	0	0	0	194.04
194.05	07955	ORTHO CAMPUS	0	0	0	0	0	194.05
194.06	07956	DR. CRAIG CLINIC	0	0	0	0	0	194.06
194.07	07957	DR. OLABIGE CLINIC	0	0	0	0	0	194.07
194.08	07958	URGENT CARE CLINIC	0	0	0	0	0	194.08
194.09	07959	DR. PACE	0	0	0	0	0	194.09
194.10	07960	SCOTTSBURG FAMILY PRACTICE (RHC)	0	0	0	0	0	194.10
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)	7,163	33,208	128,148	6,324	166,706	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1334 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part II Date/Time Prepared: 5/26/2023 9:37 am

		Cost Center Description	OPERATION OF PLANT	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
			7.00	9.00	10.00	11.00	13.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	DATA PROCESSING						5.01
5.02	00570	ADMITTING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05	00590	OTHER ADMIN AND GENERAL						5.05
7.00	00700	OPERATION OF PLANT	49,736					7.00
9.00	00900	HOUSEKEEPING	442	15,145				9.00
10.00	01000	DIETARY	1,276	0	33,956			10.00
11.00	01100	CAFETERIA	651	195	0	14,801		11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	181	2,696	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	233	0	14.00
15.00	01500	PHARMACY	0	0	0	390	65	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	845	410	0	1,016	575	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,380	3,953	31,963	3,513	723	30.00
31.00	03100	INTENSIVE CARE UNIT	390	573	666	92	54	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,489	2,867	0	560	424	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,769	696	0	1,796	0	54.00
60.00	06000	LABORATORY	1,204	1,147	0	1,859	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	100	0	63.00
65.00	06500	RESPIRATORY THERAPY	1,667	573	0	925	53	65.00
66.00	06600	PHYSICAL THERAPY	1,693	819	0	909	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	213	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	328	0	260	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	332	205	0	0	0	73.00
76.00	03610	SLEEP LAB	0	0	0	38	0	76.00
76.97	07697	CARDIAC REHABILITATION	570	205	0	163	65	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,768	0	0	0	0	88.00
91.00	09100	EMERGENCY	3,538	3,174	1,327	2,502	737	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	35,014	15,145	33,956	14,750	2,696	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	332	0	0	0	0	190.00
190.01	19001	MARKETING	0	0	0	51	0	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	SCOTT PHYSICIAN GROUP	0	0	0	0	0	192.01
194.00	07950	BUHSE CAMPUS	1,108	0	0	0	0	194.00
194.01	07951	MEDICAL SPECIALTY	1,110	0	0	0	0	194.01
194.02	07952	MEDICAL OFFICE	7,261	0	0	0	0	194.02
194.03	07953	VA PROPERTY	4,911	0	0	0	0	194.03
194.04	07954	ALREFAI CAMPUS	0	0	0	0	0	194.04
194.05	07955	ORTHO CAMPUS	0	0	0	0	0	194.05
194.06	07956	DR. CRAIG CLINIC	0	0	0	0	0	194.06
194.07	07957	DR. OLABIGE CLINIC	0	0	0	0	0	194.07
194.08	07958	URGENT CARE CLINIC	0	0	0	0	0	194.08
194.09	07959	DR. PACE	0	0	0	0	0	194.09
194.10	07960	SCOTTSBURG FAMILY PRACTICE (RHC)	0	0	0	0	0	194.10
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)	49,736	15,145	33,956	14,801	2,696	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1334 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part II Date/Time Prepared: 5/26/2023 9:37 am

		Cost Center Description	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			14.00	15.00	16.00	24.00	25.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	DATA PROCESSING						5.01
5.02	00570	ADMITTING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05	00590	OTHER ADMIN AND GENERAL						5.05
7.00	00700	OPERATION OF PLANT						7.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	695					14.00
15.00	01500	PHARMACY	183	32,090				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1	0	26,036			16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	63	0	831	222,663	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	43	9,918	0	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	27	0	323	219,008	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	20	0	6,380	87,109	0	54.00
60.00	06000	LABORATORY	175	0	6,006	80,302	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	32	0	93	6,317	0	63.00
65.00	06500	RESPIRATORY THERAPY	12	0	1,151	44,763	0	65.00
66.00	06600	PHYSICAL THERAPY	3	0	1,286	47,874	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	201	1,901	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	6	36	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	664	3,770	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	47	0	850	21,731	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6	0	4	1,093	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	32,090	3,249	55,474	0	73.00
76.00	03610	SLEEP LAB	0	0	67	409	0	76.00
76.97	07697	CARDIAC REHABILITATION	1	0	111	13,617	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	26	0	411	47,876	0	88.00
91.00	09100	EMERGENCY	98	0	4,360	122,067	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	694	32,090	26,036	985,928	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	6,421	0	190.00
190.01	19001	MARKETING	0	0	0	1,653	0	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	670	0	192.00
192.01	19201	SCOTT PHYSICIAN GROUP	0	0	0	0	0	192.01
194.00	07950	BUHSE CAMPUS	0	0	0	21,458	0	194.00
194.01	07951	MEDICAL SPECIALTY	1	0	0	23,571	0	194.01
194.02	07952	MEDICAL OFFICE	0	0	0	48,618	0	194.02
194.03	07953	VA PROPERTY	0	0	0	32,883	0	194.03
194.04	07954	ALREFAI CAMPUS	0	0	0	0	0	194.04
194.05	07955	ORTHO CAMPUS	0	0	0	0	0	194.05
194.06	07956	DR. CRAIG CLINIC	0	0	0	0	0	194.06
194.07	07957	DR. OLABIGE CLINIC	0	0	0	0	0	194.07
194.08	07958	URGENT CARE CLINIC	0	0	0	0	0	194.08
194.09	07959	DR. PACE	0	0	0	0	0	194.09
194.10	07960	SCOTTSBURG FAMILY PRACTICE (RHC)	0	0	0	0	0	194.10
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	1,385	0	0	1,385	0	201.00
202.00		TOTAL (sum lines 118 through 201)	2,080	32,090	26,036	1,122,587	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1334 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part II | Date/Time Prepared: 5/26/2023 9:37 am

		Cost Center Description	Total		
			26.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.01	00550	DATA PROCESSING			5.01
5.02	00570	ADMITTING			5.02
5.03	00560	PURCHASING RECEIVING AND STORES			5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE			5.04
5.05	00590	OTHER ADMIN AND GENERAL			5.05
7.00	00700	OPERATION OF PLANT			7.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	222,663		30.00
31.00	03100	INTENSIVE CARE UNIT	9,918		31.00
43.00	04300	NURSERY	0		43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	219,008		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	87,109		54.00
60.00	06000	LABORATORY	80,302		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	6,317		63.00
65.00	06500	RESPIRATORY THERAPY	44,763		65.00
66.00	06600	PHYSICAL THERAPY	47,874		66.00
67.00	06700	OCCUPATIONAL THERAPY	1,901		67.00
68.00	06800	SPEECH PATHOLOGY	36		68.00
69.00	06900	ELECTROCARDIOLOGY	3,770		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	21,731		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,093		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	55,474		73.00
76.00	03610	SLEEP LAB	409		76.00
76.97	07697	CARDIAC REHABILITATION	13,617		76.97
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	47,876		88.00
91.00	09100	EMERGENCY	122,067		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	985,928		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	6,421		190.00
190.01	19001	MARKETING	1,653		190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	670		192.00
192.01	19201	SCOTT PHYSICIAN GROUP	0		192.01
194.00	07950	BUHSE CAMPUS	21,458		194.00
194.01	07951	MEDICAL SPECIALTY	23,571		194.01
194.02	07952	MEDICAL OFFICE	48,618		194.02
194.03	07953	VA PROPERTY	32,883		194.03
194.04	07954	ALREFAI CAMPUS	0		194.04
194.05	07955	ORTHO CAMPUS	0		194.05
194.06	07956	DR. CRAIG CLINIC	0		194.06
194.07	07957	DR. OLABIGE CLINIC	0		194.07
194.08	07958	URGENT CARE CLINIC	0		194.08
194.09	07959	DR. PACE	0		194.09
194.10	07960	SCOTTSBURG FAMILY PRACTICE (RHC)	0		194.10
200.00		Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	1,385		201.00
202.00		TOTAL (sum lines 118 through 201)	1,122,587		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1334 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B-1 | Date/Time Prepared: 5/26/2023 9:37 am

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	DATA PROCESSING (# OF COMPU TERS)	ADMITTING (INPATIENT CHARGES)	
			1.00	2.00	4.00	5.01	5.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	129,849					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		105,064				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	8,183,601			4.00
5.01	00550	DATA PROCESSING	802	802	174,286	174		5.01
5.02	00570	ADMITTING	3,658	3,658	493,027	13	13,564,389	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	2,179	2,179	0	0	0	5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	708	708	0	0	0	5.04
5.05	00590	OTHER ADMIN AND GENERAL	16,928	16,928	600,767	14	0	5.05
7.00	00700	OPERATION OF PLANT	4,302	4,302	224,635	4	0	7.00
9.00	00900	HOUSEKEEPING	900	900	252,860	1	0	9.00
10.00	01000	DIETARY	2,599	2,599	55,577	3	0	10.00
11.00	01100	CAFETERIA	1,326	1,326	133,715	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	196,329	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	66,665	7	0	14.00
15.00	01500	PHARMACY	0	0	179,522	9	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,721	1,721	374,450	11	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	15,028	15,028	1,596,997	19	2,070,574	30.00
31.00	03100	INTENSIVE CARE UNIT	794	794	44,482	0	124,824	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	21,351	21,351	196,829	16	91,795	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,639	5,639	818,197	17	943,657	54.00
60.00	06000	LABORATORY	2,452	2,452	526,437	9	2,166,407	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	38,641	0	103,276	63.00
65.00	06500	RESPIRATORY THERAPY	3,395	3,395	332,823	0	1,076,113	65.00
66.00	06600	PHYSICAL THERAPY	3,448	3,448	63,388	9	843,250	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	8,671	0	392,587	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	274	0	7,000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	109,701	0	190,809	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	1,939,504	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	9,200	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	677	677	0	0	2,845,234	73.00
76.00	03610	SLEEP LAB	0	0	15,703	0	2,198	76.00
76.97	07697	CARDIAC REHABILITATION	1,161	1,161	61,335	10	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	3,600	3,600	530,265	15	0	88.00
91.00	09100	EMERGENCY	7,204	7,204	1,002,870	14	757,961	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	99,872	99,872	8,098,446	171	13,564,389	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	675	675	0	0	0	190.00
190.01	19001	MARKETING	0	0	24,856	0	0	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	186	3	0	192.00
192.01	19201	SCOTT PHYSICIAN GROUP	0	0	0	0	0	192.01
194.00	07950	BUHSE CAMPUS	2,256	2,256	0	0	0	194.00
194.01	07951	MEDICAL SPECIALTY	2,261	2,261	59,612	0	0	194.01
194.02	07952	MEDICAL OFFICE	14,785	0	0	0	0	194.02
194.03	07953	VA PROPERTY	10,000	0	0	0	0	194.03
194.04	07954	ALREFAI CAMPUS	0	0	0	0	0	194.04
194.05	07955	ORTHO CAMPUS	0	0	501	0	0	194.05
194.06	07956	DR. CRAIG CLINIC	0	0	0	0	0	194.06
194.07	07957	DR. OLABIGE CLINIC	0	0	0	0	0	194.07
194.08	07958	URGENT CARE CLINIC	0	0	0	0	0	194.08
194.09	07959	DR. PACE	0	0	0	0	0	194.09
194.10	07960	SCOTTSBURG FAMILY PRACTICE (RHC)	0	0	0	0	0	194.10
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)	359,647	647,403	1,005,574	1,081,084	847,999	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	2.769733	6.161987	0.122877	6,213.126437	0.062517	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			0	7,163	33,208	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000000	41.166667	0.002448	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1334 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B-1 | Date/Time Prepared: 5/26/2023 9:37 am

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	DATA PROCESSING (# OF COMPU TERS)	ADMITTING (INPATIENT CHARGES)	
			1.00	2.00	4.00	5.01	5.02	
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: 15-1334 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B-1 | Date/Time Prepared: 5/26/2023 9:37 am

		Cost Center Description	PURCHASING RECEIVING AND STORES (COSTED REQUIS.)	CASHIERING/ACCOUNTS RECEIVABLE (GROSS CHARGES)	Reconciliation	OTHER ADMIN AND GENERAL (ACCUMULATED COST)	OPERATION OF PLANT (SQUARE FEET)	
			5.03	5.04	5A.05	5.05	7.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	DATA PROCESSING						5.01
5.02	00570	ADMITTING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES	1,751,766					5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	75,415,083				5.04
5.05	00590	OTHER ADMIN AND GENERAL	204,145	0	-1,903,117	16,801,561		5.05
7.00	00700	OPERATION OF PLANT	22,068	0	0	960,802	101,272	7.00
9.00	00900	HOUSEKEEPING	30,321	0	0	444,008	900	9.00
10.00	01000	DIETARY	105,384	0	0	164,598	2,599	10.00
11.00	01100	CAFETERIA	0	0	0	212,756	1,326	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	253,463	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	19,428	0	0	13,885	0	14.00
15.00	01500	PHARMACY	359,175	0	0	484,295	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,858	0	0	728,479	1,721	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	123,756	2,409,040	0	2,510,241	15,028	30.00
31.00	03100	INTENSIVE CARE UNIT	0	124,824	0	69,736	794	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	53,974	937,512	0	877,607	21,351	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	40,146	18,441,716	0	1,773,410	5,639	54.00
60.00	06000	LABORATORY	344,979	17,408,182	0	1,576,135	2,452	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	62,244	269,916	0	127,296	0	63.00
65.00	06500	RESPIRATORY THERAPY	23,917	3,336,008	0	543,774	3,395	65.00
66.00	06600	PHYSICAL THERAPY	6,792	3,727,519	0	919,384	3,448	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	581,814	0	48,117	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	17,376	0	1,171	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,923,231	0	190,368	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	92,054	2,464,413	0	231,238	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	12,593	12,789	0	13,926	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	9,416,190	0	583,776	677	73.00
76.00	03610	SLEEP LAB	673	193,231	0	23,575	0	76.00
76.97	07697	CARDIAC REHABILITATION	1,877	321,519	0	156,859	1,161	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	50,657	1,192,232	0	916,435	3,600	88.00
91.00	09100	EMERGENCY	193,704	12,637,571	0	2,451,505	7,204	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,749,745	75,415,083	-1,903,117	16,276,839	71,295	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	6,029	675	190.00
190.01	19001	MARKETING	0	0	0	161,411	0	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	55,051	0	192.00
192.01	19201	SCOTT PHYSICIAN GROUP	0	0	0	0	0	192.01
194.00	07950	BUHSE CAMPUS	0	0	0	20,150	2,256	194.00
194.01	07951	MEDICAL SPECIALTY	2,021	0	0	213,433	2,261	194.01
194.02	07952	MEDICAL OFFICE	0	0	0	40,951	14,785	194.02
194.03	07953	VA PROPERTY	0	0	0	27,697	10,000	194.03
194.04	07954	ALREFAI CAMPUS	0	0	0	0	0	194.04
194.05	07955	ORTHO CAMPUS	0	0	-570	0	0	194.05
194.06	07956	DR. CRAIG CLINIC	0	0	0	0	0	194.06
194.07	07957	DR. OLABIGE CLINIC	0	0	0	0	0	194.07
194.08	07958	URGENT CARE CLINIC	0	0	0	0	0	194.08
194.09	07959	DR. PACE	0	0	0	0	0	194.09
194.10	07960	SCOTTSBURG FAMILY PRACTICE (RHC)	0	0	0	0	0	194.10
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)	96,117	397,107		1,903,117	1,069,632	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.054869	0.005266		0.113270	10.561972	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	128,148	6,324		166,706	49,736	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.073154	0.000084		0.009922	0.491113	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1334 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B-1 | Date/Time Prepared: 5/26/2023 9:37 am

		Cost Center Description	PURCHASING RECEIVING AND STORES (COSTED REQUIS.)	CASHIERING/ACCOUNTS RECEIVABLE (GROSS CHARGES)	Reconciliation	OTHER ADMIN AND GENERAL (ACCUMULATED COST)	OPERATION OF PLANT (SQUARE FEET)	
			5.03	5.04	5A.05	5.05	7.00	
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1334 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B-1 | Date/Time Prepared: 5/26/2023 9:37 am

		Cost Center Description	HOUSEKEEPING (MAN HOURS)	DIETARY (MEALS SERVED)	CAFETERIA (CAF))	NURSING ADMINISTRATION (HOURS SUPE RVI)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	
			9.00	10.00	11.00	13.00	14.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	DATA PROCESSING						5.01
5.02	00570	ADMITTING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05	00590	OTHER ADMIN AND GENERAL						5.05
7.00	00700	OPERATION OF PLANT						7.00
9.00	00900	HOUSEKEEPING	1,479					9.00
10.00	01000	DIETARY	0	13,303				10.00
11.00	01100	CAFETERIA	19	0	170,188			11.00
13.00	01300	NURSING ADMINISTRATION	0	0	2,080	2,080		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	2,676	0	1,370,323	14.00
15.00	01500	PHARMACY	0	0	4,483	50	359,175	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	40	0	11,684	444	1,858	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	386	12,522	40,383	558	123,756	30.00
31.00	03100	INTENSIVE CARE UNIT	56	261	1,063	42	0	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	280	0	6,439	327	53,974	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	68	0	20,653	0	40,146	54.00
60.00	06000	LABORATORY	112	0	21,381	0	344,979	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	1,154	0	62,244	63.00
65.00	06500	RESPIRATORY THERAPY	56	0	10,640	41	23,917	65.00
66.00	06600	PHYSICAL THERAPY	80	0	10,453	0	6,792	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	2,445	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	32	0	2,988	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	91,957	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	12,593	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	20	0	0	0	0	73.00
76.00	03610	SLEEP LAB	0	0	440	0	673	76.00
76.97	07697	CARDIAC REHABILITATION	20	0	1,871	50	1,877	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	50,657	88.00
91.00	09100	EMERGENCY	310	520	28,765	568	193,704	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,479	13,303	169,598	2,080	1,368,302	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	MARKETING	0	0	590	0	0	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	SCOTT PHYSICIAN GROUP	0	0	0	0	0	192.01
194.00	07950	BUHSE CAMPUS	0	0	0	0	0	194.00
194.01	07951	MEDICAL SPECIALTY	0	0	0	0	2,021	194.01
194.02	07952	MEDICAL OFFICE	0	0	0	0	0	194.02
194.03	07953	VA PROPERTY	0	0	0	0	0	194.03
194.04	07954	ALREFAI CAMPUS	0	0	0	0	0	194.04
194.05	07955	ORTHO CAMPUS	0	0	0	0	0	194.05
194.06	07956	DR. CRAIG CLINIC	0	0	0	0	0	194.06
194.07	07957	DR. OLABIGE CLINIC	0	0	0	0	0	194.07
194.08	07958	URGENT CARE CLINIC	0	0	0	0	0	194.08
194.09	07959	DR. PACE	0	0	0	0	0	194.09
194.10	07960	SCOTTSBURG FAMILY PRACTICE (RHC)	0	0	0	0	0	194.10
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)	503,807	210,693	257,332	285,318	19,504	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	340.640297	15.838006	1.512046	137.172115	0.014233	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	15,145	33,956	14,801	2,696	2,080	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	10.240027	2.552507	0.086969	1.296154	0.000507	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1334 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B-1 | Date/Time Prepared: 5/26/2023 9:37 am

		Cost Center Description	HOUSEKEEPING (MAN HOURS)	DIETARY (MEALS SERVED)	CAFETERIA (CAF))	NURSING ADMINISTRATION (HOURS SUPE RVI)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	
			9.00	10.00	11.00	13.00	14.00	
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1334 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B-1 | Date/Time Prepared: 5/26/2023 9:37 am

		Cost Center Description	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)		
			15.00	16.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.01	00550	DATA PROCESSING				5.01
5.02	00570	ADMITTING				5.02
5.03	00560	PURCHASING RECEIVING AND STORES				5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE				5.04
5.05	00590	OTHER ADMIN AND GENERAL				5.05
7.00	00700	OPERATION OF PLANT				7.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY	350,273			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	75,415,083		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	2,409,040		30.00
31.00	03100	INTENSIVE CARE UNIT	0	124,824		31.00
43.00	04300	NURSERY	0	0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	937,512		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	18,441,716		54.00
60.00	06000	LABORATORY	0	17,408,182		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	269,916		63.00
65.00	06500	RESPIRATORY THERAPY	0	3,336,008		65.00
66.00	06600	PHYSICAL THERAPY	0	3,727,519		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	581,814		67.00
68.00	06800	SPEECH PATHOLOGY	0	17,376		68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,923,231		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	2,464,413		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	12,789		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	350,273	9,416,190		73.00
76.00	03610	SLEEP LAB	0	193,231		76.00
76.97	07697	CARDIAC REHABILITATION	0	321,519		76.97
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	1,192,232		88.00
91.00	09100	EMERGENCY	0	12,637,571		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	350,273	75,415,083		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
190.01	19001	MARKETING	0	0		190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
192.01	19201	SCOTT PHYSICIAN GROUP	0	0		192.01
194.00	07950	BUHSE CAMPUS	0	0		194.00
194.01	07951	MEDICAL SPECIALTY	0	0		194.01
194.02	07952	MEDICAL OFFICE	0	0		194.02
194.03	07953	VA PROPERTY	0	0		194.03
194.04	07954	ALREFAI CAMPUS	0	0		194.04
194.05	07955	ORTHO CAMPUS	0	0		194.05
194.06	07956	DR. CRAIG CLINIC	0	0		194.06
194.07	07957	DR. OLABIGE CLINIC	0	0		194.07
194.08	07958	URGENT CARE CLINIC	0	0		194.08
194.09	07959	DR. PACE	0	0		194.09
194.10	07960	SCOTTSBURG FAMILY PRACTICE (RHC)	0	0		194.10
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)	557,902	921,394		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	1.592763	0.012218		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	32,090	26,036		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.091614	0.000345		205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)				206.00

COST ALLOCATION - STATISTICAL BASIS	Provider CCN: 15-1334	Period: From 01/01/2022 To 12/31/2022	Worksheet B-1 Date/Time Prepared: 5/26/2023 9:37 am

		Cost Center Description	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)				
			15.00	16.00				
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1334 | Period: From 01/01/2022 To 12/31/2022 | Worksheet C Part I Date/Time Prepared: 5/26/2023 9:37 am

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,451,913		3,451,913	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	118,124		118,124	0	0	31.00
43.00	04300	NURSERY	0		0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,364,716		1,364,716	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,314,099		2,314,099	0	0	54.00
60.00	06000	LABORATORY	2,068,646		2,068,646	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	147,644		147,644	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	723,112	0	723,112	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,148,637	0	1,148,637	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	64,373	0	64,373	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,516	0	1,516	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	250,847		250,847	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	288,849		288,849	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	15,838		15,838	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,336,812		1,336,812	0	0	73.00
76.00	03610	SLEEP LAB	29,281		29,281	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	207,344		207,344	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,073,551		1,073,551	0	0	88.00
91.00	09100	EMERGENCY	3,197,680		3,197,680	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	558,991		558,991		0	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	18,361,973	0	18,361,973	0	0	200.00
201.00		Less Observation Beds	558,991		558,991		0	201.00
202.00		Total (see instructions)	17,802,982	0	17,802,982	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1334 | Period: From 01/01/2022 To 12/31/2022 | Worksheet C Part I Date/Time Prepared: 5/26/2023 9:37 am

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	2,042,216		2,042,216			30.00
31.00	03100	INTENSIVE CARE UNIT	124,824		124,824			31.00
43.00	04300	NURSERY	0		0			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	91,795	845,717	937,512	1.455678	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	943,657	17,498,059	18,441,716	0.125482	0.000000	54.00
60.00	06000	LABORATORY	2,166,407	15,241,775	17,408,182	0.118832	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	103,276	166,640	269,916	0.547000	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	1,076,113	2,259,895	3,336,008	0.216760	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	843,250	2,884,269	3,727,519	0.308151	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	392,587	189,227	581,814	0.110642	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	7,000	10,376	17,376	0.087247	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	190,809	1,732,422	1,923,231	0.130430	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,939,504	524,909	2,464,413	0.117208	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	9,200	3,589	12,789	1.238408	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,845,234	6,570,956	9,416,190	0.141970	0.000000	73.00
76.00	03610	SLEEP LAB	2,198	191,033	193,231	0.151534	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	321,519	321,519	0.644889	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	1,192,232	1,192,232			88.00
91.00	09100	EMERGENCY	757,961	11,879,610	12,637,571	0.253030	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	28,358	338,466	366,824	1.523867	0.000000	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	13,564,389	61,850,694	75,415,083			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	13,564,389	61,850,694	75,415,083			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1334 | Period: From 01/01/2022 To 12/31/2022 | Worksheet C Part I Date/Time Prepared: 5/26/2023 9:37 am

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000		63.00
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	03610	SLEEP LAB	0.000000		76.00
76.97	07697	CARDIAC REHABILITATION	0.000000		76.97
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC			88.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
		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: 15-1334 | Period: From 01/01/2022 To 12/31/2022 | Worksheet C Part I Date/Time Prepared: 5/26/2023 9:37 am

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	3,451,913		3,451,913	0	3,451,913	30.00
31.00	03100	INTENSIVE CARE UNIT	118,124		118,124	0	118,124	31.00
43.00	04300	NURSERY	0		0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,364,716		1,364,716	0	1,364,716	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,314,099		2,314,099	0	2,314,099	54.00
60.00	06000	LABORATORY	2,068,646		2,068,646	0	2,068,646	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	147,644		147,644	0	147,644	63.00
65.00	06500	RESPIRATORY THERAPY	723,112	0	723,112	0	723,112	65.00
66.00	06600	PHYSICAL THERAPY	1,148,637	0	1,148,637	0	1,148,637	66.00
67.00	06700	OCCUPATIONAL THERAPY	64,373	0	64,373	0	64,373	67.00
68.00	06800	SPEECH PATHOLOGY	1,516	0	1,516	0	1,516	68.00
69.00	06900	ELECTROCARDIOLOGY	250,847		250,847	0	250,847	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	288,849		288,849	0	288,849	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	15,838		15,838	0	15,838	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,336,812		1,336,812	0	1,336,812	73.00
76.00	03610	SLEEP LAB	29,281		29,281	0	29,281	76.00
76.97	07697	CARDIAC REHABILITATION	207,344		207,344	0	207,344	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,073,551		1,073,551	0	1,073,551	88.00
91.00	09100	EMERGENCY	3,197,680		3,197,680	0	3,197,680	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	558,991		558,991		558,991	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	18,361,973	0	18,361,973	0	18,361,973	200.00
201.00		Less Observation Beds	558,991		558,991		558,991	201.00
202.00		Total (see instructions)	17,802,982	0	17,802,982	0	17,802,982	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1334 | Period: From 01/01/2022 To 12/31/2022 | Worksheet C Part I Date/Time Prepared: 5/26/2023 9:37 am

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	2,042,216		2,042,216			30.00
31.00	03100	INTENSIVE CARE UNIT	124,824		124,824			31.00
43.00	04300	NURSERY	0		0			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	91,795	845,717	937,512	1.455678	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	943,657	17,498,059	18,441,716	0.125482	0.000000	54.00
60.00	06000	LABORATORY	2,166,407	15,241,775	17,408,182	0.118832	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	103,276	166,640	269,916	0.547000	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	1,076,113	2,259,895	3,336,008	0.216760	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	843,250	2,884,269	3,727,519	0.308151	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	392,587	189,227	581,814	0.110642	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	7,000	10,376	17,376	0.087247	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	190,809	1,732,422	1,923,231	0.130430	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,939,504	524,909	2,464,413	0.117208	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	9,200	3,589	12,789	1.238408	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,845,234	6,570,956	9,416,190	0.141970	0.000000	73.00
76.00	03610	SLEEP LAB	2,198	191,033	193,231	0.151534	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	321,519	321,519	0.644889	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	1,192,232	1,192,232	0.900455	0.000000	88.00
91.00	09100	EMERGENCY	757,961	11,879,610	12,637,571	0.253030	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	28,358	338,466	366,824	1.523867	0.000000	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	13,564,389	61,850,694	75,415,083			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	13,564,389	61,850,694	75,415,083			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1334 | Period: From 01/01/2022 To 12/31/2022 | Worksheet C Part I Date/Time Prepared: 5/26/2023 9:37 am

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000		63.00
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	03610	SLEEP LAB	0.000000		76.00
76.97	07697	CARDIAC REHABILITATION	0.000000		76.97
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
		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: 15-1334 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part II Date/Time Prepared: 5/26/2023 9:37 am

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	219,008	937,512	0.233606	27,994	6,540	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	87,109	18,441,716	0.004723	282,596	1,335	54.00
60.00	06000	LABORATORY	80,302	17,408,182	0.004613	670,440	3,093	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	6,317	269,916	0.023404	22,032	516	63.00
65.00	06500	RESPIRATORY THERAPY	44,763	3,336,008	0.013418	267,111	3,584	65.00
66.00	06600	PHYSICAL THERAPY	47,874	3,727,519	0.012843	59,250	761	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,901	581,814	0.003267	14,826	48	67.00
68.00	06800	SPEECH PATHOLOGY	36	17,376	0.002072	1,105	2	68.00
69.00	06900	ELECTROCARDIOLOGY	3,770	1,923,231	0.001960	76,149	149	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	21,731	2,464,413	0.008818	493,836	4,355	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,093	12,789	0.085464	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	55,474	9,416,190	0.005891	632,941	3,729	73.00
76.00	03610	SLEEP LAB	409	193,231	0.002117	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	13,617	321,519	0.042352	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	47,876	1,192,232	0.040157	0	0	88.00
91.00	09100	EMERGENCY	122,067	12,637,571	0.009659	239,105	2,310	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	36,057	366,824	0.098295	12,927	1,271	92.00
200.00		Total (lines 50 through 199)	789,404	73,248,043		2,800,312	27,693	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1334 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part IV Date/Time Prepared: 5/26/2023 9:37 am

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
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	03610	SLEEP LAB	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
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: 15-1334 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part IV Date/Time Prepared: 5/26/2023 9:37 am

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	937,512	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	18,441,716	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	17,408,182	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	269,916	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	3,336,008	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	3,727,519	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	581,814	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	17,376	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	1,923,231	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	2,464,413	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	12,789	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	9,416,190	0.000000	73.00
76.00	03610	SLEEP LAB	0	0	0	193,231	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	321,519	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	1,192,232	0.000000	88.00
91.00	09100	EMERGENCY	0	0	0	12,637,571	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	366,824	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	73,248,043		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1334 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part IV Date/Time Prepared: 5/26/2023 9:37 am

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	27,994	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	282,596	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	670,440	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	22,032	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.000000	267,111	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	59,250	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	14,826	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	1,105	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	76,149	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	493,836	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	632,941	0	0	0	73.00
76.00	03610	SLEEP LAB	0.000000	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
91.00	09100	EMERGENCY	0.000000	239,105	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	12,927	0	0	0	92.00
200.00		Total (lines 50 through 199)		2,800,312	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1334 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part V Date/Time Prepared: 5/26/2023 9:37 am

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	1.455678	0	158,290	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.125482	0	3,641,526	0	0	54.00
60.00	06000	LABORATORY	0.118832	0	3,027,734	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.547000	0	54,863	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.216760	0	641,953	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.308151	0	793,514	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.110642	0	58,320	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.087247	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.130430	0	454,487	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.117208	0	125,418	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1.238408	0	401	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.141970	0	1,251,868	121,010	0	73.00
76.00	03610	SLEEP LAB	0.151534	0	37,139	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.644889	0	133,052	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC						88.00
91.00	09100	EMERGENCY	0.253030	0	1,874,478	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.523867	0	76,331	0	0	92.00
200.00		Subtotal (see instructions)		0	12,329,374	121,010	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	12,329,374	121,010	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1334 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part V Date/Time Prepared: 5/26/2023 9:37 am

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	230,419	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	456,946	0		54.00
60.00	06000	LABORATORY	359,792	0		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	30,010	0		63.00
65.00	06500	RESPIRATORY THERAPY	139,150	0		65.00
66.00	06600	PHYSICAL THERAPY	244,522	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	6,453	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	59,279	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	14,700	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	497	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	177,728	17,180		73.00
76.00	03610	SLEEP LAB	5,628	0		76.00
76.97	07697	CARDIAC REHABILITATION	85,804	0		76.97
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC				88.00
91.00	09100	EMERGENCY	474,299	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	116,318	0		92.00
200.00		Subtotal (see instructions)	2,401,545	17,180		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	2,401,545	17,180		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1334 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part V Date/Time Prepared: 5/26/2023 9:37 am

Title XIX | 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	1.455678	0	16,451	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.125482	0	287,485	0	0	54.00
60.00	06000	LABORATORY	0.118832	0	354,190	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.547000	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.216760	0	44,917	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.308151	0	23,920	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.110642	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.087247	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.130430	0	30,138	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.117208	0	18,497	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1.238408	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.141970	0	183,158	0	0	73.00
76.00	03610	SLEEP LAB	0.151534	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.644889	0	5,561	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC						88.00
91.00	09100	EMERGENCY	0.253030	0	379,150	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.523867	0	15,335	0	0	92.00
200.00		Subtotal (see instructions)		0	1,358,802	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	1,358,802	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1334 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part V Date/Time Prepared: 5/26/2023 9:37 am

Title XIX | 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	23,947	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	36,074	0		54.00
60.00	06000	LABORATORY	42,089	0		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
65.00	06500	RESPIRATORY THERAPY	9,736	0		65.00
66.00	06600	PHYSICAL THERAPY	7,371	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	3,931	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,168	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	26,003	0		73.00
76.00	03610	SLEEP LAB	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	3,586	0		76.97
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC				88.00
91.00	09100	EMERGENCY	95,936	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	23,369	0		92.00
200.00		Subtotal (see instructions)	274,210	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	274,210	0		202.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-1334	Period: From 01/01/2022 To 12/31/2022	Worksheet D-1 Date/Time Prepared: 5/26/2023 9:37 am
	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)	3,999	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,108	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,486	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	1,672	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	219	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	606	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)	904	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	250.44	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	250.44	20.00
21.00	Total general inpatient routine service cost (see instructions)	3,451,913	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)	54,846	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)	1,557,456	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	1,894,457	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)	1,894,457	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)	898.69	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	544,606	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)	544,606	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1334 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-1 | Date/Time Prepared: 5/26/2023 9:37 am

Title XVIII | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	118,124	87	1,357.75	35	47,521	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)	483,699	48.00
48.01	Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)	0	48.01
49.00	Total Program inpatient costs (sum of lines 41 through 48.01)(see instructions)	1,075,826	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
55.01	Permanent adjustment amount per discharge	0.00	55.01
55.02	Adjustment amount per discharge (contractor use only)	0.00	55.02
56.00	Target amount (line 54 x sum of lines 55, 55.01, and 55.02)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)	0.00	59.00
60.00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)	0.00	60.00
61.00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	812,416	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	812,416	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)	622	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	898.70	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	558,991	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1334 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-1 | Date/Time Prepared: 5/26/2023 9:37 am

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	222,663	3,451,913	0.064504	558,991	36,057	90.00
91.00	Nursing Program cost	0	3,451,913	0.000000	558,991	0	91.00
92.00	Allied health cost	0	3,451,913	0.000000	558,991	0	92.00
93.00	All other Medical Education	0	3,451,913	0.000000	558,991	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-1334	Period: From 01/01/2022 To 12/31/2022	Worksheet D-1 Date/Time Prepared: 5/26/2023 9:37 am
	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)	3,999	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,108	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,486	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	1,672	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	219	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	42	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	250.44	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	250.44	20.00
21.00	Total general inpatient routine service cost (see instructions)	3,451,913	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)	54,846	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)	1,557,456	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	1,894,457	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)	1,894,457	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)	898.69	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	37,745	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)	37,745	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1334 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-1 | Date/Time Prepared: 5/26/2023 9:37 am

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)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	118,124	87	1,357.75	3	4,073	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)	57,918	48.00
48.01	Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)	0	48.01
49.00	Total Program inpatient costs (sum of lines 41 through 48.01)(see instructions)	99,736	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
55.01	Permanent adjustment amount per discharge	0.00	55.01
55.02	Adjustment amount per discharge (contractor use only)	0.00	55.02
56.00	Target amount (line 54 x sum of lines 55, 55.01, and 55.02)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)	0.00	59.00
60.00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)	0.00	60.00
61.00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	622	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	898.70	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	558,991	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1334 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-1 | Date/Time Prepared: 5/26/2023 9:37 am

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	222,663	3,451,913	0.064504	558,991	36,057	90.00
91.00	Nursing Program cost	0	3,451,913	0.000000	558,991	0	91.00
92.00	Allied health cost	0	3,451,913	0.000000	558,991	0	92.00
93.00	All other Medical Education	0	3,451,913	0.000000	558,991	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1334 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-3 | Date/Time Prepared: 5/26/2023 9:37 am

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		512,181		30.00
31.00	03100	INTENSIVE CARE UNIT		50,455		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	1.455678	27,994	40,750	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.125482	282,596	35,461	54.00
60.00	06000	LABORATORY	0.118832	670,440	79,670	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.547000	22,032	12,052	63.00
65.00	06500	RESPIRATORY THERAPY	0.216760	267,111	57,899	65.00
66.00	06600	PHYSICAL THERAPY	0.308151	59,250	18,258	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.110642	14,826	1,640	67.00
68.00	06800	SPEECH PATHOLOGY	0.087247	1,105	96	68.00
69.00	06900	ELECTROCARDIOLOGY	0.130430	76,149	9,932	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.117208	493,836	57,882	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1.238408	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.141970	632,941	89,859	73.00
76.00	03610	SLEEP LAB	0.151534	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.644889	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
91.00	09100	EMERGENCY	0.253030	239,105	60,501	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.523867	12,927	19,699	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		2,800,312	483,699	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)		2,800,312		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-1334 | Component CCN: 15-Z334 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-3 | Date/Time Prepared: 5/26/2023 9:37 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	1.455678	2,907	4,232	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.125482	27,665	3,471	54.00
60.00	06000	LABORATORY	0.118832	223,259	26,530	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.547000	10,839	5,929	63.00
65.00	06500	RESPIRATORY THERAPY	0.216760	144,475	31,316	65.00
66.00	06600	PHYSICAL THERAPY	0.308151	355,585	109,574	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.110642	170,115	18,822	67.00
68.00	06800	SPEECH PATHOLOGY	0.087247	3,776	329	68.00
69.00	06900	ELECTROCARDIOLOGY	0.130430	4,920	642	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.117208	410,463	48,110	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1.238408	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.141970	338,024	47,989	73.00
76.00	03610	SLEEP LAB	0.151534	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.644889	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
91.00	09100	EMERGENCY	0.253030	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.523867	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,692,028	296,944	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)		1,692,028		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1334 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-3 | Date/Time Prepared: 5/26/2023 9:37 am

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		39,263		30.00
31.00	03100	INTENSIVE CARE UNIT		4,353		31.00
43.00	04300	NURSERY		0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	1.455678	3,865	5,626	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.125482	31,649	3,971	54.00
60.00	06000	LABORATORY	0.118832	87,402	10,386	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.547000	6,048	3,308	63.00
65.00	06500	RESPIRATORY THERAPY	0.216760	31,918	6,919	65.00
66.00	06600	PHYSICAL THERAPY	0.308151	8,181	2,521	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.110642	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.087247	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.130430	9,635	1,257	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.117208	30,883	3,620	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1.238408	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.141970	57,362	8,144	73.00
76.00	03610	SLEEP LAB	0.151534	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.644889	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.900455	0	0	88.00
91.00	09100	EMERGENCY	0.253030	44,571	11,278	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.523867	583	888	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		312,097	57,918	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)		312,097		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1334	Period: From 01/01/2022 To 12/31/2022	Worksheet E Part B Date/Time Prepared: 5/26/2023 9:37 am
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	2,418,725	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)	2,418,725	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)	2,442,912	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)	54,975	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	1,721,534	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)	666,403	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)	666,403	30.00
31.00	Primary payer payments	315	31.00
32.00	Subtotal (line 30 minus line 31)	666,088	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)	203,684	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	132,395	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	120,828	36.00
37.00	Subtotal (see instructions)	798,483	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.75	N95 respirator payment adjustment amount (see instructions)	0	39.75
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	798,483	40.00
40.01	Sequestration adjustment (see instructions)	10,061	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
40.03	Sequestration adjustment-PARHM or CHART pass-throughs		40.03
41.00	Interim payments	1,096,247	41.00
41.01	Interim payments-PARHM or CHART		41.01
42.00	Tentative settlement (for contractors use only)	0	42.00
42.01	Tentative settlement-PARHM or CHART (for contractor use only)		42.01
43.00	Balance due provider/program (see instructions)	-307,825	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: 15-1334	Period: From 01/01/2022 To 12/31/2022	Worksheet E Part B Date/Time Prepared: 5/26/2023 9:37 am
	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: 15-1334 | Period: From 01/01/2022 To 12/31/2022 | Worksheet E-1 Part I Date/Time Prepared: 5/26/2023 9:37 am

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		871,076		1,096,247	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	10/12/2022	90,500		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		90,500		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		961,576		1,096,247	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		133,696		307,825	6.02
7.00	Total Medicare program liability (see instructions)		827,880		788,422	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: 15-1334 | Component CCN: 15-Z334 | Period: From 01/01/2022 To 12/31/2022 | Worksheet E-1 Part I | Date/Time Prepared: 5/26/2023 9:37 am

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		965,013		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	10/12/2022	67,500		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		67,500		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,032,513		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		53,405		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,085,918		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: 15-1334	Period: From 01/01/2022 To 12/31/2022	Worksheet E-1 Part II Date/Time Prepared: 5/26/2023 9:37 am
	Title XVIII	Hospital	Cost

			1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14		1.00
2.00	Medicare days (see instructions)		2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2		3.00
4.00	Total inpatient days (see instructions)		4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200		5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20		6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168		7.00
8.00	Calculation of the HIT incentive payment (see instructions)		8.00
9.00	Sequestration adjustment amount (see instructions)		9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)		10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)		30.00
31.00	Other Adjustment (specify)		31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)		32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS | Provider CCN: 15-1334 | Component CCN: 15-Z334 | Period: From 01/01/2022 To 12/31/2022 | Worksheet E-2 | Date/Time Prepared: 5/26/2023 9:37 am

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)	820,540	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)	299,913	0	3.00
3.01	Nursing and allied health payment-PARHM or CHART (see instructions)			3.01
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	904	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)	1,120,453	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	1,120,453	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)	1,120,453	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	24,354	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (see instructions)	1,096,099	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)	5,656	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	3,676	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	1,099,775	0	19.00
19.01	Sequestration adjustment (see instructions)	13,857	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0	0	19.02
19.03	Sequestration adjustment-PARHM or CHART pass-throughs			19.03
19.25	Sequestration for non-claims based amounts (see instructions)	0	0	19.25
20.00	Interim payments	1,032,513	0	20.00
20.01	Interim payments-PARHM or CHART			20.01
21.00	Tentative settlement (for contractor use only)	0	0	21.00
21.01	Tentative settlement-PARHM or CHART (for contractor use only)			21.01
22.00	Balance due provider/program (line 19 minus lines 19.01, 19.02, 19.25, 20, and 21)	53,405	0	22.00
22.01	Balance due provider/program-PARHM or CHART (see instructions)			22.01
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	23.00
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
	Cost Reimbursement			
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))			201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))			202.00
203.00	Total (sum of lines 201 and 202)			203.00
204.00	Medicare swing-bed SNF discharges (see instructions)			204.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
205.00	Medicare swing-bed SNF target amount			205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)			206.00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)			208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
	Comparision of PPS versus Cost Reimbursement			
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)			215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1334	Period: From 01/01/2022 To 12/31/2022	Worksheet E-3 Part V Date/Time Prepared: 5/26/2023 9:37 am
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	1,075,826	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)	0	2.00
3.00	Organ acquisition	0	3.00
3.01	Cellular therapy acquisition cost (see instructions)	0	3.01
4.00	Subtotal (sum of lines 1 through 3.01)	1,075,826	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	1,086,584	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)	1,086,584	19.00
20.00	Deductibles (exclude professional component)	269,602	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	816,982	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	816,982	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	33,019	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	21,462	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	674	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	838,444	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)	838,444	30.00
30.01	Sequestration adjustment (see instructions)	10,564	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
30.03	Sequestration adjustment-PARHM or CHART		30.03
31.00	Interim payments	961,576	31.00
31.01	Interim payments-PARHM or CHART		31.01
32.00	Tentative settlement (for contractor use only)	0	32.00
32.01	Tentative settlement-PARHM or CHART (for contractor use only)		32.01
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)	-133,696	33.00
33.01	Balance due provider/program-PARHM or CHART (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01)		33.01
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1334	Period: From 01/01/2022 To 12/31/2022	Worksheet E-3 Part VII Date/Time Prepared: 5/26/2023 9:37 am
	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	99,736		1.00
2.00	Medical and other services		274,210	2.00
3.00	Organ acquisition (certified transplant programs only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	99,736	274,210	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)	99,736	274,210	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	43,616		8.00
9.00	Ancillary service charges	312,097	1,358,802	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)	355,713	1,358,802	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)	355,713	1,358,802	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	255,977	1,084,592	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	99,736	274,210	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)	99,736	274,210	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	99,736	274,210	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)	99,736	274,210	36.00
37.00	ADJUST COST TO PAYMENT RECEIVED	-30,109	-161,279	37.00
38.00	Subtotal (line 36 ± line 37)	69,627	112,931	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)	69,627	112,931	40.00
41.00	Interim payments	69,627	112,931	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	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: 15-1334 | Period: From 01/01/2022 To 12/31/2022 | Worksheet G | Date/Time Prepared: 5/26/2023 9:37 am

		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	17,048	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	2,323,718	0	0	0	4.00
5.00	Other receivable	1,057,094	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	524,981	0	0	0	7.00
8.00	Prepaid expenses	309,337	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	4,232,178	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	428,000	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	2,791,088	0	0	0	15.00
16.00	Accumulated depreciation	-762,586	0	0	0	16.00
17.00	Leasehold improvements	462,127	0	0	0	17.00
18.00	Accumulated depreciation	-92,663	0	0	0	18.00
19.00	Fixed equipment	397,318	0	0	0	19.00
20.00	Accumulated depreciation	-81,806	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	1,273,269	0	0	0	23.00
24.00	Accumulated depreciation	-786,435	0	0	0	24.00
25.00	Minor equipment depreciable	1,172,889	0	0	0	25.00
26.00	Accumulated depreciation	-688,246	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)	4,112,955	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	1,973,796	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	1,973,796	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	10,318,929	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	866,486	0	0	0	37.00
38.00	Salaries, wages, and fees payable	604,816	0	0	0	38.00
39.00	Payroll taxes payable	264,477	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	237,995	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	1,973,774	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	1,654,932	0	0	0	46.00
47.00	Notes payable	65,152	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)	1,720,084	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	3,693,858	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	6,625,071				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)	6,625,071	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	10,318,929	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-1334 | Period: From 01/01/2022 To 12/31/2022 | Worksheet G-1 | Date/Time Prepared: 5/26/2023 9:37 am

		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		2,740,135		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		3,069,111				2.00
3.00	Total (sum of line 1 and line 2)		5,809,246		0		3.00
4.00	IMPUTED INCOME TAX	815,840		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)		815,840		0		10.00
11.00	Subtotal (line 3 plus line 10)		6,625,086		0		11.00
12.00	ROUNDING	15		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)		15		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		6,625,071		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	IMPUTED INCOME TAX		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	ROUNDING		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: 15-1334 | Period: From 01/01/2022 To 12/31/2022 | Worksheet G-2 Parts I & II Date/Time Prepared: 5/26/2023 9:37 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	1,278,824		1,278,824	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	763,057		763,057	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)	2,041,881		2,041,881	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	124,824		124,824	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)	124,824		124,824	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	2,166,705		2,166,705	17.00
18.00	Ancillary services	10,611,031	48,440,388	59,051,419	18.00
19.00	Outpatient services	782,969	12,221,761	13,004,730	19.00
20.00	RURAL HEALTH CLINIC	0	1,192,232	1,192,232	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	NURSERY	0	0	0	27.00
27.01	PRIVATE PHYSICIAN OFFICE	0	14,932	14,932	27.01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	13,560,705	61,869,313	75,430,018	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		21,144,375		29.00
30.00	IMPUTED INCOME TAX	815,840			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)		815,840		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)		21,960,215		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 15-1334	Period: From 01/01/2022 To 12/31/2022	Worksheet G-3 Date/Time Prepared: 5/26/2023 9:37 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	75,430,018	1.00
2.00	Less contractual allowances and discounts on patients' accounts	53,819,236	2.00
3.00	Net patient revenues (line 1 minus line 2)	21,610,782	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	21,960,215	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-349,433	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	80,896	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	736	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	1,515	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISCELLANEOUS INCOME	1,091,303	24.00
24.50	COVID-19 PHE Funding	2,244,094	24.50
25.00	Total other income (sum of lines 6-24)	3,418,544	25.00
26.00	Total (line 5 plus line 25)	3,069,111	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	3,069,111	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1334 | Component CCN: 15-8523 | Period: From 01/01/2022 To 12/31/2022 | Worksheet M-1 | Date/Time Prepared: 5/26/2023 9:37 am

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	246,273	0	246,273	0	246,273	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	102,717	0	102,717	0	102,717	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	30,150	0	30,150	608	30,758	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	73,892	0	73,892	0	73,892	9.00
10.00	Subtotal (sum of lines 1 through 9)	453,032	0	453,032	608	453,640	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	20,740	20,740	0	20,740	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	20,740	20,740	0	20,740	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	453,032	20,740	473,772	608	474,380	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	14,370	14,370	0	14,370	29.00
30.00	Administrative Costs	0	228,067	228,067	53	228,120	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	242,437	242,437	53	242,490	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	453,032	263,177	716,209	661	716,870	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1334 | Component CCN: 15-8523 | Period: From 01/01/2022 To 12/31/2022 | Worksheet M-1 | Date/Time Prepared: 5/26/2023 9:37 am

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	246,273		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	102,717		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	30,758		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	73,892		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	453,640		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		14.00
15.00	Medical Supplies	0	20,740		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	20,740		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	474,380		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	14,370		29.00
30.00	Administrative Costs	0	228,120		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	242,490		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	716,870		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-1334 | Component CCN: 15-8523 | Period: From 01/01/2022 To 12/31/2022 | Worksheet M-2 | Date/Time Prepared: 5/26/2023 9:37 am

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	0.46	1,237	4,200	1,932		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	1.00	2,075	2,100	2,100		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.46	3,312		4,032	4,032	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)	1.46	3,312			4,032	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)					474,380	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)					474,380	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)					242,490	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					356,681	15.00
16.00	Total overhead (sum of lines 14 and 15)					599,171	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					599,171	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					599,171	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					1,073,551	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 15-1334 Component CCN: 15-8523	Period: From 01/01/2022 To 12/31/2022	Worksheet M-3 Date/Time Prepared: 5/26/2023 9:37 am
	Title XVIII	RHC I	Cost

			1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)		1,073,551	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)		16,823	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)		1,056,728	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		4,032	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)		0	5.00
6.00	Total adjusted visits (line 4 plus line 5)		4,032	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		262.09	7.00

		Calculation of Limit (1)		
		Rate Period N/A	Rate Period 1 (01/01/2022 through 12/31/2022)	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	0.00	215.88	8.00
9.00	Rate for Program covered visits (see instructions)	0.00	215.88	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	661	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	142,697	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	142,697	16.00
16.01	Total program charges (see instructions)(from contractor's records)		139,795	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		5,927	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		6,050	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.)		93,398	16.04
16.05	Total program cost (see instructions)	0	99,448	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		19,900	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		22,793	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		99,448	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		4,563	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		104,011	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)		104,011	26.00
26.01	Sequestration adjustment (see instructions)		1,311	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		98,083	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)		4,617	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: 15-1334 | Component CCN: 15-8523 | Period: From 01/01/2022 To 12/31/2022 | Worksheet M-4 | Date/Time Prepared: 5/26/2023 9:37 am

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)	453,640	453,640	453,640	453,640	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000186	0.001925	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	84	873	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	1,852	4,625	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	1,936	5,498	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	474,380	474,380	474,380	474,380	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	599,171	599,171	599,171	599,171	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.004081	0.011590	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	2,445	6,944	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	4,381	12,442	0	0	10.00
11.00	Total number of injections/infusions (from your records)	12	124	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	365.08	100.34	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	7	20	0	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	2,556	2,007	0	0	14.00

			COST OF INJECTIONS / INFUSIONS AND ADMINISTRATION	
		1.00	2.00	
15.00	Total cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. M-3, line 2)		16,823	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)		4,563	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 15-1334 Component CCN: 15-8523	Period: From 01/01/2022 To 12/31/2022	Worksheet M-5 Date/Time Prepared: 5/26/2023 9:37 am
		RHC I	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		98,083	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)		98,083	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		4,617	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		102,700	7.00

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