

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: 15-0128	Period: From 01/01/2022 To 12/31/2022	Worksheet S Parts I-III Date/Time Prepared: 5/25/2023 11:46 am
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PART I - COST REPORT STATUS

Provider use only	1. <input checked="" type="checkbox"/> Electronically prepared cost report 2. <input type="checkbox"/> Manually prepared cost report	Date: 5/25/2023 Time: 11:46 am
	3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report 4. <input checked="" type="checkbox"/> Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no.	
Contractor use only	5. <input checked="" type="checkbox"/> 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. <input checked="" type="checkbox"/> Initial Report for this Provider CCN 9. <input checked="" type="checkbox"/> Final Report for this Provider CCN 10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> 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 COMMUNITY HOSPITAL SOUTH (15-0128) 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	Holly Millard	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	Holly Millard		2
3	Signatory Title	SVP OF FINANCE		3
4	Date	(Dated when report is electronic)		4

	Title V	Title XVIII		HIT	Title XIX	
		Part A	Part B			
	1.00	2.00	3.00	4.00	5.00	
PART III - SETTLEMENT SUMMARY						
1.00	HOSPITAL	0	534,311	-40,497	0	0 1.00
2.00	SUBPROVIDER - IPF	0	0	0	0	0 2.00
3.00	SUBPROVIDER - IRF	0	0	0	0	0 3.00
5.00	SWING BED - SNF	0	0	0	0	0 5.00
6.00	SWING BED - NF	0	0	0	0	0 6.00
200.00	TOTAL	0	534,311	-40,497	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: 15-0128	Period: From 01/01/2022 To 12/31/2022	Worksheet S-2 Part I Date/Time Prepared: 5/25/2023 11:46 am
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1.00	Hospital and Hospital Health Care Complex Address:	2.00	3.00	4.00	1.00
2.00	Street: 1402 EAST COUNTY LINE ROAD SOUTH	PO Box:	Zip Code: 46227	County: MARION	2.00
	City: INDIANAPOLIS	State: IN			

	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	COMMUNITY HOSPITAL SOUTH	150128	26900	1	07/01/1966	N	P	P	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
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)					2				21.00

	1.00	2.00	3.00	
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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.	Y	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)	Y	Y							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.	3	N							23.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0128			Period: From 01/01/2022 To 12/31/2022		Worksheet S-2 Part I Date/Time Prepared: 5/25/2023 11:46 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.	1,593	529	0	17	8,556	32	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.					1		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.					1		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	XVII	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 impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2.					Y	Y		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.					Y			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

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		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
61.01	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
62.00	ACA Provisions Affecting the Health Resources and Services Administration (HRSA) 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
63.00	Teaching Hospitals that Claim Residents in Nonprovider Settings 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

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			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	
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	2.02	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)	FAMILY MEDICINE	1350	0.00	5.78	0.000000	

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			1.00		
68.00	Direct GME in Accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022) 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.		N		86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.		N		87.00
			Approved for Permanent Adjustment (Y/N)	Number of Approved Permanent Adjustments	
			1.00	2.00	
88.00	Column 1: Is this hospital approved for a permanent adjustment to the TEFRA target amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete col. 2 and line 89. (see instructions) Column 2: Enter the number of approved permanent adjustments.				0 88.00
			Wkst. A Line No.	Effective Date	Approved Permanent Adjustment Amount Per Discharge
			1.00	2.00	3.00
89.00	Column 1: If line 88, column 1 is Y, enter the Worksheet A line number on which the per discharge permanent adjustment approval was based. Column 2: Enter the effective date (i.e., the cost reporting period beginning date) for the permanent adjustment to the TEFRA target amount per discharge. Column 3: Enter the amount of the approved permanent adjustment to the TEFRA target amount per discharge.		0.00		0 89.00
			V	XIX	
			1.00	2.00	
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.		N		Y 90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.		N		N 91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N		N 92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.		N		N 93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.		N		N 94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.		0.00		0.00 95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.		N		N 96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.		0.00		0.00 97.00

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		V 1.00	XIX 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	N	98.00	
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. 1? 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?	N		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)			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)			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 1.00	Occupational 2.00	Speech 3.00	Respiratory 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.				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
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			115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	Y			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.		1		118.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0128	Period: From 01/01/2022 To 12/31/2022	Worksheet S-2 Part I Date/Time Prepared: 5/25/2023 11:46 am
		Premiums	Losses	Insurance
		1.00	2.00	3.00
118.01	List amounts of malpractice premiums and paid losses:	1,445,600	0	0
		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	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	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: COMMUNITY HEALTH NETWORK	Contractor's Name: WISCONSIN PHYSICIANS SERVICES		141.00
142.00	Street: 1500 NORTH RITTER AVENUE	Contractor's Number: 08101		142.00
143.00	City: INDIANAPOLIS	PO Box:	State: IN	143.00
		Zip Code:	46219-3095	
		1.00	2.00	
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.		Y	145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.		N	146.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0128		Period: From 01/01/2022 To 12/31/2022		Worksheet S-2 Part I Date/Time Prepared: 5/25/2023 11:46 am		
1.00								
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.						Y	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.						N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.						N	149.00
		Part A	Part B	Title V	Title XIX			
		1.00	2.00	3.00	4.00			
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)								
155.00	Hospital	N	N	N	N		155.00	
156.00	Subprovider - IPF	N	N	N	N		156.00	
157.00	Subprovider - IRF	N	N	N	N		157.00	
158.00	SUBPROVIDER						158.00	
159.00	SNF	N	N	N	N		159.00	
160.00	HOME HEALTH AGENCY	N	N	N	N		160.00	
161.00	CMHC		N	N	N		161.00	
1.00								
Multi campus								
165.00	Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.						N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00	166.00
1.00								
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act								
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.						Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)							168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)							168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)						9.99	169.00
		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	0171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-0128		Period: From 01/01/2022 To 12/31/2022		Worksheet S-2 Part II Date/Time Prepared: 5/25/2023 11:46 am	
		Y/N	Date				
		1.00	2.00				
PART II - HOSPITAL AND HOSPITAL HEALTHCARE 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				
		1.00	2.00				
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)	Y					3.00
		Y/N	Type				
		1.00	2.00				
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	03/31/2022			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.	Y					9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N					10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N					11.00
		Y/N					
		1.00					
Bad Debts							
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.				Y		12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.				N		13.00
14.00	If line 12 is yes, were patient deductibles and/or coinsurance amounts waived? If yes, see instructions.				N		14.00
Bed Complement							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.				N		15.00
		Part A		Part B			
		Y/N	Date	Y/N	Date		
		1.00	2.00	3.00	4.00		
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		N			16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	05/02/2022	Y	05/02/2022		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: 15-0128	Period: From 01/01/2022 To 12/31/2022	Worksheet S-2 Part II Date/Time Prepared: 5/25/2023 11:46 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 relieved for Medicare purposes? If yes, see instructions				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.				23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				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.				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				29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				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.				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.				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.				35.00
			Y/N	Date	
			1.00	2.00	
Home Office Costs					
36.00	Were home office costs claimed on the cost report?				36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.				37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.				38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.				39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.				40.00
		1.00		2.00	
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	SHIRLEY		BI SHOP	41.00
42.00	Enter the employer/company name of the cost report preparer.	COMMUNITY HEALTH NETWORK			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-355-4135		SBI SHOP@ECOMMUNITY.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-0128	Period: From 01/01/2022 To 12/31/2022	Worksheet S-2 Part II Date/Time Prepared: 5/25/2023 11:46 am
		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.	NETWORK DIRECTOR OF REIMBURSEMENT		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: 15-0128

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

Worksheet S-3
Part I
Date/Time Prepared:
5/25/2023 11:46 am

Component	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P		
	Line No.				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	157	57,305	0.00	0	1.00	
2.00 HMO and other (see instructions)						2.00	
3.00 HMO IPF Subprovider						3.00	
4.00 HMO IRF Subprovider						4.00	
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00	
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00	
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		157	57,305	0.00	0	7.00	
8.00 INTENSIVE CARE UNIT	31.00	12	4,380	0.00	0	8.00	
9.00 CORONARY CARE UNIT						9.00	
10.00 BURN INTENSIVE CARE UNIT						10.00	
11.00 SURGICAL INTENSIVE CARE UNIT						11.00	
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00	
13.00 NURSERY	43.00				0	13.00	
14.00 Total (see instructions)		169	61,685	0.00	0	14.00	
15.00 CAH visits					0	15.00	
16.00 SUBPROVIDER - IPF						16.00	
17.00 SUBPROVIDER - IRF						17.00	
18.00 SUBPROVIDER						18.00	
19.00 SKILLED NURSING FACILITY						19.00	
20.00 NURSING FACILITY						20.00	
21.00 OTHER LONG TERM CARE						21.00	
22.00 HOME HEALTH AGENCY						22.00	
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00	
24.00 HOSPICE						24.00	
24.10 HOSPICE (non-distinct part)	30.00					24.10	
25.00 CMHC - CMHC						25.00	
26.00 RURAL HEALTH CLINIC						26.00	
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25	
27.00 Total (sum of lines 14-26)		169				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: 15-0128

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

Worksheet S-3
Part I
Date/Time Prepared:
5/25/2023 11:46 am

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVII I	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)	9,075	1,219	35,032		1.00
2.00	HMO and other (see instructions)	10,412	7,891			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	0	0	0		5.00
6.00	Hospital Adults & Peds. Swing Bed NF	0	0	0		6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	9,075	1,219	35,032		7.00
8.00	INTENSIVE CARE UNIT	940	209	3,075		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		1,376	2,245		13.00
14.00	Total (see instructions)	10,015	2,804	40,352	7.80	14.00
15.00	CAH visits	0	0	0		15.00
16.00	SUBPROVIDER - IPF					16.00
17.00	SUBPROVIDER - IRF					17.00
18.00	SUBPROVIDER					18.00
19.00	SKILLED NURSING FACILITY					19.00
20.00	NURSING FACILITY					20.00
21.00	OTHER LONG TERM CARE					21.00
22.00	HOME HEALTH AGENCY					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)					23.00
24.00	HOSPICE					24.00
24.10	HOSPICE (non-distinct part)			79		24.10
25.00	CMHC - CMHC					25.00
26.00	RURAL HEALTH CLINIC					26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00
27.00	Total (sum of lines 14-26)				7.80	904.88
28.00	Observation Bed Days		900	5,781		28.00
29.00	Ambulance Trips	0				29.00
30.00	Employee discount days (see instruction)			354		30.00
31.00	Employee discount days - IRF			0		31.00
32.00	Labor & delivery days (see instructions)	0	32	638		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: 15-0128

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

Worksheet S-3
Part I
Date/Time Prepared:
5/25/2023 11:46 am

Component	Full Time Equivalents	Discharges			Total All Patients		
		Nonpaid Workers	Title V	Title XVIII			Title XIX
		11.00	12.00	13.00			14.00
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	2,349	294	9,420	1.00
2.00	HMO and other (see instructions)			1,984	2,010		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	2,349	294	9,420	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						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 WAGE INDEX INFORMATION

Provider CCN: 15-0128

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

Worksheet S-3
Part II
Date/Time Prepared:
5/25/2023 11:46 am

	Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART II - WAGE DATA							
SALARIES							
1.00	Total salaries (see instructions)	200.00	79,204,459	-349,024	78,855,435	1,882,151.00	41.90
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00
4.00	Physician-Part A - Administrative		839,088	0	839,088	7,080.00	118.52
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician and Non-Physician-Part B		326,423	0	326,423	4,088.00	79.85
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00
9.00	SNF	44.00	0	0	0	0.00	0.00
10.00	Excluded area salaries (see instructions)		910,808	-2,717	908,091	27,383.00	33.16
OTHER WAGES & RELATED COSTS							
11.00	Contract Labor: Direct Patient Care		9,362,100	0	9,362,100	72,835.00	128.54
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00
13.00	Contract Labor: Physician-Part A - Administrative		1,333,254	0	1,333,254	14,241.00	93.62
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00
14.01	Home office salaries		0	0	0	0.00	0.00
14.02	Related organization salaries		0	0	0	0.00	0.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00
16.02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00
WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		19,476,596	0	19,476,596		
18.00	Wage-related costs (other) (see instructions)						
19.00	Excluded areas		272,141	0	272,141		
20.00	Non-physician anesthetist Part A		0	0	0		
21.00	Non-physician anesthetist Part B		0	0	0		
22.00	Physician Part A - Administrative		89,960	0	89,960		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		51,943	0	51,943		
24.00	Wage-related costs (RHC/FQHC)		0	0	0		
25.00	Interns & residents (in an approved program)		0	0	0		
25.50	Home office wage-related (core)		0	0	0		
25.51	Related organization wage-related (core)		0	0	0		
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0		

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0128

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

Worksheet S-3
Part II
Date/Time Prepared:
5/25/2023 11:46 am

	Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
25.53	Home office: Physicians Part A - Teaching - wage-related (core)	0	0	0			25.53
OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	0	0	0	0.00	0.00	26.00
27.00	Administrative & General	3,544,521	-17,067	3,527,454	115,452.00	30.55	27.00
28.00	Administrative & General under contract (see inst.)	3,894,320	0	3,894,320	35,588.00	109.43	28.00
29.00	Maintenance & Repairs	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	792,376	-2,917	789,459	21,694.00	36.39	30.00
31.00	Laundry & Linen Service	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	1,703,472	-5,906	1,697,566	86,581.00	19.61	32.00
33.00	Housekeeping under contract (see instructions)	343,177	0	343,177	7,072.00	48.53	33.00
34.00	Dietary	1,553,917	-1,039,525	514,392	23,587.00	21.81	34.00
35.00	Dietary under contract (see instructions)	294,109	0	294,109	4,160.00	70.70	35.00
36.00	Cafeteria	0	1,039,024	1,039,024	47,597.00	21.83	36.00
37.00	Maintenance of Personnel	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	377,175	-500	376,675	19,305.00	19.51	38.00
39.00	Central Services and Supply	0	0	0	0.00	0.00	39.00
40.00	Pharmacy	0	0	0	0.00	0.00	40.00
41.00	Medical Records & Medical Records Library	0	0	0	0.00	0.00	41.00
42.00	Social Service	1,426,794	0	1,426,794	32,713.00	43.62	42.00
43.00	Other General Service	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0128

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

Worksheet S-3
Part III
Date/Time Prepared:
5/25/2023 11:46 am

	Worksheet A Line Number	Amount Reported	Recl assi fi cati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col . 2 ± col . 3)	Paid Hours Related to Salaries in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	83,409,642	-349,024	83,060,618	1,924,883.00	43.15	1.00
2.00	Excluded area salaries (see instructions)	910,808	-2,717	908,091	27,383.00	33.16	2.00
3.00	Subtotal salaries (line 1 minus line 2)	82,498,834	-346,307	82,152,527	1,897,500.00	43.30	3.00
4.00	Subtotal other wages & related costs (see inst.)	10,695,354	0	10,695,354	87,076.00	122.83	4.00
5.00	Subtotal wage-related costs (see inst.)	19,566,556	0	19,566,556	0.00	23.82	5.00
6.00	Total (sum of lines 3 thru 5)	112,760,744	-346,307	112,414,437	1,984,576.00	56.64	6.00
7.00	Total overhead cost (see instructions)	13,929,861	-26,891	13,902,970	393,749.00	35.31	7.00

HOSPITAL WAGE RELATED COSTS	Provider CCN: 15-0128	Period: From 01/01/2022 To 12/31/2022	Worksheet S-3 Part IV Date/Time Prepared: 5/25/2023 11:46 am
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		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	3,058,227	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	49,939	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)			
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	618,173	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
HEALTH AND INSURANCE COST			
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	6,602,370	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	2,464,726	9.00
10.00	Dental, Hearing and Vision Plan	67,356	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	35,312	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	933,422	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	263,097	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Noncumulative portion)	0	16.00
TAXES			
17.00	FICA-Employers Portion Only	5,790,899	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
OTHER			
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	7,119	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	19,890,640	24.00
Part B - Other than Core Related Cost			
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST		Provider CCN: 15-0128	Period: From 01/01/2022 To 12/31/2022	Worksheet S-3 Part V Date/Time Prepared: 5/25/2023 11:46 am
Cost Center Description			Contract Labor	Benefit Cost
			1.00	2.00
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost		9,362,100	19,890,640
2.00	Hospital		9,362,100	19,618,499
3.00	SUBPROVIDER - IPF			
4.00	SUBPROVIDER - IRF			
5.00	Subprovider - (Other)		0	0
6.00	Swing Beds - SNF		0	0
7.00	Swing Beds - NF		0	0
8.00	SKILLED NURSING FACILITY			
9.00	NURSING FACILITY			
10.00	OTHER LONG TERM CARE I			
11.00	Hospital-Based HHA			
12.00	AMBULATORY SURGICAL CENTER (D.P.) I			
13.00	Hospital-Based Hospice			
14.00	Hospital-Based Health Clinic RHC			
15.00	Hospital-Based Health Clinic FQHC			
16.00	Hospital-Based-CMHC			
17.00	RENAL DIALYSIS I		0	0
18.00	Other		0	272,141

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 15-0128	Period: From 01/01/2022 To 12/31/2022	Worksheet S-10 Date/Time Prepared: 5/25/2023 11:46 am
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			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)		0.206089	1.00	
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		56,681,796	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		-16,262,687	5.00	
6.00	Medicaid charges		239,170,421	6.00	
7.00	Medicaid cost (line 1 times line 6)		49,290,393	7.00	
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)		8,871,284	8.00	
Children's Health Insurance Program (CHIP) (see instructions for each line)					
9.00	Net revenue from stand-alone CHIP		0	9.00	
10.00	Stand-alone CHIP charges		0	10.00	
11.00	Stand-alone CHIP cost (line 1 times line 10)		0	11.00	
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)		0	12.00	
Other state or local government indigent care program (see instructions for each line)					
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0	13.00	
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0	14.00	
15.00	State or local indigent care program cost (line 1 times line 14)		0	15.00	
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)		0	16.00	
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)					
17.00	Private grants, donations, or endowment income restricted to funding charity care		0	17.00	
18.00	Government grants, appropriations or transfers for support of hospital operations		0	18.00	
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		8,871,284	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)	8,022,538	1,802,596	9,825,134	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	1,653,357	1,802,596	3,455,953	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)	1,653,357	1,802,596	3,455,953	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)			14,742,323	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)			155,821	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)			239,724	27.01
28.00	Non-Medicare bad debt expense (see instructions)			14,502,599	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)			3,072,729	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)			6,528,682	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			15,399,966	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES			Provider CCN: 15-0128		Period: From 01/01/2022 To 12/31/2022		Worksheet A	
Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassified (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		0	0	10,756,637	10,756,637	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	9,063,665	9,063,665	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	6	6	0	6	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,544,521	87,679,588	91,224,109	-9,956,149	81,267,960	5.00
7.00	00700	OPERATION OF PLANT	792,376	4,195,705	4,988,081	-118,141	4,869,940	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	676,619	676,619	0	676,619	8.00
9.00	00900	HOUSEKEEPING	1,703,472	1,232,599	2,936,071	-17,686	2,918,385	9.00
10.00	01000	DIETARY	1,553,917	1,868,311	3,422,228	-2,296,608	1,125,620	10.00
11.00	01100	CAFETERIA	0	0	0	2,266,867	2,266,867	11.00
13.00	01300	NURSING ADMINISTRATION	377,175	94,316	471,491	0	471,491	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	1,426,794	364,391	1,791,185	-1,844	1,789,341	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	28,774,258	21,549,144	50,323,402	-7,604,261	42,719,141	30.00
31.00	03100	INTENSIVE CARE UNIT	3,992,768	1,709,482	5,702,250	-467,801	5,234,449	31.00
43.00	04300	NURSERY	0	0	0	970,721	970,721	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	3,662,484	20,615,177	24,277,661	-16,672,471	7,605,190	50.00
51.00	05100	RECOVERY ROOM	3,361,956	1,496,798	4,858,754	-291,762	4,566,992	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	615,486	26,343	641,829	4,893,232	5,535,061	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,315,036	2,057,086	4,372,122	-1,321,717	3,050,405	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	813,746	2,211,067	3,024,813	-1,340,495	1,684,318	55.00
57.00	05700	CT SCAN	1,008,852	1,379,155	2,388,007	-201,595	2,186,412	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	535,110	423,298	958,408	-106,194	852,214	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,649,756	9,327,153	10,976,909	-7,681,335	3,295,574	59.00
60.00	06000	LABORATORY	0	9,094,521	9,094,521	-2,173	9,092,348	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	2,617,886	1,248,656	3,866,542	-434,692	3,431,850	65.00
66.00	06600	PHYSICAL THERAPY	3,546,291	1,690,014	5,236,305	-1,780,908	3,455,397	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,047,231	1,047,231	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	226,699	226,699	68.00
69.00	06900	ELECTROCARDIOLOGY	1,220,190	549,629	1,769,819	-59,888	1,709,931	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	539,636	420,456	960,092	-137,204	822,888	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	484,165	1,343,406	1,827,571	13,645,176	15,472,747	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	9,572,835	9,572,835	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,462,070	8,412,859	11,874,929	-69,502	11,805,427	73.00
74.00	07400	RENAL DIALYSIS	11,756	545,753	557,509	-38,327	519,182	74.00
76.00	03950	ENDOSCOPY	717,086	1,136,000	1,853,086	-681,224	1,171,862	76.00
76.06	03330	IMAGING CENTER	1,075,865	1,148,096	2,223,961	-506,143	1,717,818	76.06
76.97	07697	CARDIAC REHABILITATION	369,272	145,798	515,070	-28,232	486,838	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	04950	DIABETIC CARE CENTER	0	0	0	0	0	90.01
90.02	04951	ANTI-COAGULATION CLINIC	561,933	174,462	736,395	-13,922	722,473	90.02
90.03	04952	PALLIATIVE CARE	0	0	0	0	0	90.03
90.04	04953	SPINE CENTER	247,617	168,719	416,336	-72,710	343,626	90.04
91.00	09100	EMERGENCY	7,312,177	7,181,391	14,493,568	-533,424	13,960,144	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	78,293,651	190,165,998	268,459,649	6,655	268,466,304	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	109,662	109,662	0	109,662	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	HOME OFFICE	0	0	0	0	0	194.00
194.06	07956	LEASED OFFICE SPACE	0	0	0	0	0	194.06
194.08	07958	MISC NONREIMBURSABLE COST CENTERS	910,808	764,384	1,675,192	-6,655	1,668,537	194.08
200.00		TOTAL (SUM OF LINES 118 through 199)	79,204,459	191,040,044	270,244,503	0	270,244,503	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-0128

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

Worksheet A
Date/Time Prepared:
5/25/2023 11:46 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	-3,342,510	7,414,127	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2,000,398	11,064,063	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4,021,999	4,022,005	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-43,534,100	37,733,860	5.00
7.00	00700	OPERATION OF PLANT	1,525,229	6,395,169	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	676,619	8.00
9.00	00900	HOUSEKEEPING	0	2,918,385	9.00
10.00	01000	DIETARY	-14,880	1,110,740	10.00
11.00	01100	CAFETERIA	-1,340,876	925,991	11.00
13.00	01300	NURSING ADMINISTRATION	3,568,873	4,040,364	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,517,043	1,517,043	16.00
17.00	01700	SOCIAL SERVICE	0	1,789,341	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	687,420	687,420	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	1,455,126	1,455,126	22.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-5,390,278	37,328,863	30.00
31.00	03100	INTENSIVE CARE UNIT	0	5,234,449	31.00
43.00	04300	NURSERY	0	970,721	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-67,200	7,537,990	50.00
51.00	05100	RECOVERY ROOM	0	4,566,992	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	5,535,061	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-203,206	2,847,199	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	1,684,318	55.00
57.00	05700	CT SCAN	0	2,186,412	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	852,214	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	3,295,574	59.00
60.00	06000	LABORATORY	0	9,092,348	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	3,431,850	65.00
66.00	06600	PHYSICAL THERAPY	9,000	3,464,397	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,047,231	67.00
68.00	06800	SPEECH PATHOLOGY	0	226,699	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,709,931	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	154,488	977,376	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,006,081	16,478,828	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	9,572,835	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	116,292	11,921,719	73.00
74.00	07400	RENAL DIALYSIS	0	519,182	74.00
76.00	03950	ENDOSCOPY	0	1,171,862	76.00
76.06	03330	IMAGING CENTER	0	1,717,818	76.06
76.97	07697	CARDIAC REHABILITATION	0	486,838	76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	90.00
90.01	04950	DIABETIC CARE CENTER	0	0	90.01
90.02	04951	ANTI-COAGULATION CLINIC	-326,423	396,050	90.02
90.03	04952	PALLIATIVE CARE	0	0	90.03
90.04	04953	SPINE CENTER	0	343,626	90.04
91.00	09100	EMERGENCY	599,291	14,559,435	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-37,558,233	230,908,071	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
191.00	19100	RESEARCH	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	109,662	192.00
193.00	19300	NONPAID WORKERS	0	0	193.00
194.00	07950	HOME OFFICE	0	0	194.00
194.06	07956	LEASED OFFICE SPACE	0	0	194.06
194.08	07958	MISC NONREIMBURSABLE COST CENTERS	0	1,668,537	194.08
200.00		TOTAL (SUM OF LINES 118 through 199)	-37,558,233	232,686,270	200.00

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
A - Chargeable Medical Supplies					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	15,026,803	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
TOTALS			0	15,026,803	
B - Implantable Device Reclass					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	9,572,835	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
TOTALS			0	9,572,835	
C - Drugs Charges to Pat					
1.00	ELECTROCARDIOLOGY	69.00	0	104,407	1.00
2.00	DRUGS CHARGED TO PATIENTS	73.00	0	461,902	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
TOTALS			0	566,309	
D - Depreciation Expense					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	10,787,115	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00

RECLASSIFICATIONS

Provider CCN: 15-0128

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

Worksheet A-6
Date/Time Prepared:
5/25/2023 11:46 am

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
26.00		0.00	0	0	26.00
27.00		0.00	0	0	27.00
28.00		0.00	0	0	28.00
	TOTALS		0	10,787,115	
E - Interest Expense					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	5,302,871	1.00
	TOTALS		0	5,302,871	
F - Other Capital Rental					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	3,503,883	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
	TOTALS		0	3,503,883	
G - STD BENEFIT					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	17,067	1.00
2.00	OPERATION OF PLANT	7.00	0	2,917	2.00
3.00	HOUSEKEEPING	9.00	0	5,906	3.00
4.00	DIETARY	10.00	0	501	4.00
5.00	NURSING ADMINISTRATION	13.00	0	500	5.00
6.00	ADULTS & PEDIATRICS	30.00	0	131,041	6.00
7.00	INTENSIVE CARE UNIT	31.00	0	16,682	7.00
8.00	OPERATING ROOM	50.00	0	18,382	8.00
9.00	RECOVERY ROOM	51.00	0	4,903	9.00
10.00	RADIOLOGY-DIAGNOSTIC	54.00	0	4,868	10.00
11.00	RADIOLOGY-THERAPEUTIC	55.00	0	5,940	11.00
12.00	CT SCAN	57.00	0	2,296	12.00
13.00	RESPIRATORY THERAPY	65.00	0	17,730	13.00
14.00	PHYSICAL THERAPY	66.00	0	14,094	14.00
15.00	ELECTROCARDIOLOGY	69.00	0	5,343	15.00
16.00	ELECTROENCEPHALOGRAPHY	70.00	0	2,023	16.00
17.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	1,696	17.00
18.00	DRUGS CHARGED TO PATIENTS	73.00	0	37,360	18.00
19.00	ENDOSCOPY	76.00	0	3,824	19.00
20.00	IMAGING CENTER	76.06	0	6,342	20.00
21.00	ANTI-COAGULATION CLINIC	90.02	0	28,175	21.00
22.00	EMERGENCY	91.00	0	18,717	22.00
23.00	MISC NONREIMBURSABLE COST CENTERS	194.08	0	2,717	23.00
	TOTALS		0	349,024	
H - Labor and Delivery					
1.00	NURSERY	43.00	688,962	0	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	3,472,933	0	2.00
3.00	NURSERY	43.00	0	281,759	3.00
4.00	DELIVERY ROOM & LABOR ROOM	52.00	0	1,420,299	4.00
	TOTALS		4,161,895	1,702,058	
I - Cafeteria					
1.00	CAFETERIA	11.00	1,039,024	0	1.00
2.00	CAFETERIA	11.00	0	1,227,843	2.00
	TOTALS		1,039,024	1,227,843	
J - Therapy					
1.00	OCCUPATIONAL THERAPY	67.00	784,897	0	1.00
2.00	SPEECH PATHOLOGY	68.00	169,910	0	2.00
3.00	OCCUPATIONAL THERAPY	67.00	0	262,334	3.00

Increases					
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
4.00	SPEECH PATHOLOGY	68.00	0	56,789	4.00
	TOTALS		954,807	319,123	
K - Building Depreciation					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	5,227,333	1.00
	TOTALS		0	5,227,333	
L - Capital Insurance Costs					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	226,433	1.00
	TOTALS		0	226,433	
M - Radiology Support Staff					
1.00	RADIOLOGY-THERAPEUTIC	55.00	57,125	0	1.00
2.00	CT SCAN	57.00	172,316	0	2.00
3.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	34,526	0	3.00
4.00	RADIOLOGY-THERAPEUTIC	55.00	0	45,374	4.00
5.00	CT SCAN	57.00	0	136,869	5.00
6.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	27,423	6.00
	TOTALS		263,967	209,666	
500.00	Grand Total: Increases		6,419,693	54,021,296	500.00

RECLASSIFICATIONS

Provider CCN: 15-0128

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

Worksheet A-6
Date/Time Prepared:
5/25/2023 11:46 am

Decreases							
Cost Center	Line #	Salary	Other	Wkst.	A-7 Ref.		
6.00	7.00	8.00	9.00	10.00			
A - Chargeable Medical Supplies							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	7,520	0		1.00
2.00	DIETARY	10.00	0	339	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	1,256,067	0		3.00
4.00	INTENSIVE CARE UNIT	31.00	0	328,630	0		4.00
5.00	OPERATING ROOM	50.00	0	6,966,540	0		5.00
6.00	RECOVERY ROOM	51.00	0	208,546	0		6.00
7.00	RADIOLOGY-DIAGNOSTIC	54.00	0	429,155	0		7.00
8.00	RADIOLOGY-THERAPEUTIC	55.00	0	926,584	0		8.00
9.00	CT SCAN	57.00	0	305,166	0		9.00
10.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	22,357	0		10.00
11.00	CARDIAC CATHETERIZATION	59.00	0	3,196,021	0		11.00
12.00	RESPIRATORY THERAPY	65.00	0	414,161	0		12.00
13.00	PHYSICAL THERAPY	66.00	0	1,575	0		13.00
14.00	ELECTROCARDIOLOGY	69.00	0	13,742	0		14.00
15.00	ELECTROENCEPHALOGRAPHY	70.00	0	9,455	0		15.00
16.00	DRUGS CHARGED TO PATIENTS	73.00	0	105,997	0		16.00
17.00	RENAL DIALYSIS	74.00	0	37,960	0		17.00
18.00	ENDOSCOPY	76.00	0	463,614	0		18.00
19.00	IMAGING CENTER	76.06	0	42,746	0		19.00
20.00	CARDIAC REHABILITATION	76.97	0	2,900	0		20.00
21.00	EMERGENCY	91.00	0	287,728	0		21.00
TOTALS			0	15,026,803			
B - Implantable Device Recl							
1.00	OPERATING ROOM	50.00	0	5,688,143	0		1.00
2.00	RADIOLOGY-THERAPEUTIC	55.00	0	241,361	0		2.00
3.00	CARDIAC CATHETERIZATION	59.00	0	3,643,331	0		3.00
TOTALS			0	9,572,835			
C - Drugs Charges to Pat							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	1,711	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	53,773	0		2.00
3.00	INTENSIVE CARE UNIT	31.00	0	8,572	0		3.00
4.00	OPERATING ROOM	50.00	0	20,395	0		4.00
5.00	RECOVERY ROOM	51.00	0	7,311	0		5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00	0	148,051	0		6.00
7.00	RADIOLOGY-THERAPEUTIC	55.00	0	493	0		7.00
8.00	CT SCAN	57.00	0	173,757	0		8.00
9.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	4,012	0		9.00
10.00	CARDIAC CATHETERIZATION	59.00	0	62,993	0		10.00
11.00	PHYSICAL THERAPY	66.00	0	658	0		11.00
12.00	ELECTROENCEPHALOGRAPHY	70.00	0	488	0		12.00
13.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	7,871	0		13.00
14.00	RENAL DIALYSIS	74.00	0	367	0		14.00
15.00	ENDOSCOPY	76.00	0	597	0		15.00
16.00	IMAGING CENTER	76.06	0	58,899	0		16.00
17.00	CARDIAC REHABILITATION	76.97	0	2	0		17.00
18.00	EMERGENCY	91.00	0	14,002	0		18.00
19.00	MISC NONREIMBURSABLE COST CENTERS	194.08	0	2,357	0		19.00
TOTALS			0	566,309			
D - Depreciation Expense							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	4,113,766	9		1.00
2.00	OPERATION OF PLANT	7.00	0	111,854	0		2.00
3.00	HOUSEKEEPING	9.00	0	4,226	0		3.00
4.00	DIETARY	10.00	0	27,780	0		4.00
5.00	SOCIAL SERVICE	17.00	0	1,805	0		5.00
6.00	ADULTS & PEDIATRICS	30.00	0	379,711	0		6.00
7.00	INTENSIVE CARE UNIT	31.00	0	130,599	0		7.00
8.00	OPERATING ROOM	50.00	0	3,446,792	0		8.00
9.00	RECOVERY ROOM	51.00	0	72,633	0		9.00
10.00	RADIOLOGY-DIAGNOSTIC	54.00	0	270,878	0		10.00
11.00	RADIOLOGY-THERAPEUTIC	55.00	0	274,375	0		11.00
12.00	CT SCAN	57.00	0	20,602	0		12.00
13.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	102,924	0		13.00
14.00	CARDIAC CATHETERIZATION	59.00	0	777,261	0		14.00
15.00	LABORATORY	60.00	0	2,173	0		15.00
16.00	RESPIRATORY THERAPY	65.00	0	20,373	0		16.00
17.00	PHYSICAL THERAPY	66.00	0	97,448	0		17.00
18.00	ELECTROCARDIOLOGY	69.00	0	150,467	0		18.00
19.00	ELECTROENCEPHALOGRAPHY	70.00	0	20,855	0		19.00

RECLASSIFICATIONS

Provider CCN: 15-0128

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

Worksheet A-6

Date/Time Prepared:
5/25/2023 11:46 am

Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
20.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	31,269	0	20.00
21.00	DRUGS CHARGED TO PATIENTS	73.00	0	76,788	0	21.00
22.00	ENDOSCOPY	76.00	0	216,342	0	22.00
23.00	IMAGING CENTER	76.06	0	148,090	0	23.00
24.00	CARDIAC REHABILITATION	76.97	0	25,330	0	24.00
25.00	ANTI-COAGULATION CLINIC	90.02	0	13,922	0	25.00
26.00	SPINE CENTER	90.04	0	12,860	0	26.00
27.00	EMERGENCY	91.00	0	231,694	0	27.00
28.00	MISC NONREIMBURSABLE COST CENTERS	194.08	0	4,298	0	28.00
	TOTALS		0	10,787,115		
E - Interest Expense						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	5,302,871	11	1.00
	TOTALS		0	5,302,871		
F - Other Capital Rental						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	303,848	10	1.00
2.00	OPERATION OF PLANT	7.00	0	6,287	0	2.00
3.00	HOUSEKEEPING	9.00	0	13,460	0	3.00
4.00	DIETARY	10.00	0	1,622	0	4.00
5.00	SOCIAL SERVICE	17.00	0	39	0	5.00
6.00	ADULTS & PEDIATRICS	30.00	0	50,757	0	6.00
7.00	OPERATING ROOM	50.00	0	550,601	0	7.00
8.00	RECOVERY ROOM	51.00	0	3,272	0	8.00
9.00	RADIOLOGY-THERAPEUTIC	55.00	0	181	0	9.00
10.00	CT SCAN	57.00	0	11,255	0	10.00
11.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	38,850	0	11.00
12.00	CARDIAC CATHETERIZATION	59.00	0	1,729	0	12.00
13.00	RESPIRATORY THERAPY	65.00	0	158	0	13.00
14.00	PHYSICAL THERAPY	66.00	0	407,297	0	14.00
15.00	ELECTROCARDIOLOGY	69.00	0	86	0	15.00
16.00	ELECTROENCEPHALOGRAPHY	70.00	0	106,406	0	16.00
17.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	1,342,487	0	17.00
18.00	DRUGS CHARGED TO PATIENTS	73.00	0	348,619	0	18.00
19.00	ENDOSCOPY	76.00	0	671	0	19.00
20.00	IMAGING CENTER	76.06	0	256,408	0	20.00
21.00	SPINE CENTER	90.04	0	59,850	0	21.00
	TOTALS		0	3,503,883		
G - STD BENEFIT						
1.00	ADMINISTRATIVE & GENERAL	5.00	17,067	0	0	1.00
2.00	OPERATION OF PLANT	7.00	2,917	0	0	2.00
3.00	HOUSEKEEPING	9.00	5,906	0	0	3.00
4.00	DIETARY	10.00	501	0	0	4.00
5.00	NURSING ADMINISTRATION	13.00	500	0	0	5.00
6.00	ADULTS & PEDIATRICS	30.00	131,041	0	0	6.00
7.00	INTENSIVE CARE UNIT	31.00	16,682	0	0	7.00
8.00	OPERATING ROOM	50.00	18,382	0	0	8.00
9.00	RECOVERY ROOM	51.00	4,903	0	0	9.00
10.00	RADIOLOGY-DIAGNOSTIC	54.00	4,868	0	0	10.00
11.00	RADIOLOGY-THERAPEUTIC	55.00	5,940	0	0	11.00
12.00	CT SCAN	57.00	2,296	0	0	12.00
13.00	RESPIRATORY THERAPY	65.00	17,730	0	0	13.00
14.00	PHYSICAL THERAPY	66.00	14,094	0	0	14.00
15.00	ELECTROCARDIOLOGY	69.00	5,343	0	0	15.00
16.00	ELECTROENCEPHALOGRAPHY	70.00	2,023	0	0	16.00
17.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	1,696	0	0	17.00
18.00	DRUGS CHARGED TO PATIENTS	73.00	37,360	0	0	18.00
19.00	ENDOSCOPY	76.00	3,824	0	0	19.00
20.00	IMAGING CENTER	76.06	6,342	0	0	20.00
21.00	ANTI-COAGULATION CLINIC	90.02	28,175	0	0	21.00
22.00	EMERGENCY	91.00	18,717	0	0	22.00
23.00	MISC NONREIMBURSABLE COST CENTERS	194.08	2,717	0	0	23.00
	TOTALS		349,024	0		
H - Labor and Delivery						
1.00	ADULTS & PEDIATRICS	30.00	4,161,895	0	0	1.00
2.00		0.00	0	0	0	2.00
3.00	ADULTS & PEDIATRICS	30.00	0	1,702,058	0	3.00
4.00		0.00	0	0	0	4.00
	TOTALS		4,161,895	1,702,058		

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
I - Cafeteria							
1.00	DIETARY	10.00	1,039,024	0	0	1.00	
2.00	DIETARY	10.00	0	1,227,843	0	2.00	
	TOTALS		1,039,024	1,227,843			
J - Therapy							
1.00	PHYSICAL THERAPY	66.00	954,807	0	0	1.00	
2.00		0.00	0	0	0	2.00	
3.00	PHYSICAL THERAPY	66.00	0	319,123	0	3.00	
4.00		0.00	0	0	0	4.00	
	TOTALS		954,807	319,123			
K - Building Depreciation							
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	5,227,333	9	1.00	
	TOTALS		0	5,227,333			
L - Capital Insurance Costs							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	226,433	12	1.00	
	TOTALS		0	226,433			
M - Radiology Support Staff							
1.00	RADIOLOGY-DIAGNOSTIC	54.00	263,967	0	0	1.00	
2.00		0.00	0	0	0	2.00	
3.00		0.00	0	0	0	3.00	
4.00	RADIOLOGY-DIAGNOSTIC	54.00	0	209,666	0	4.00	
5.00		0.00	0	0	0	5.00	
6.00		0.00	0	0	0	6.00	
	TOTALS		263,967	209,666			
500.00	Grand Total: Decreases		6,768,717	53,672,272		500.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0128

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

Worksheet A-7
Part I
Date/Time Prepared:
5/25/2023 11:46 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	1,821,632	3,620,455	0	3,620,455	0	1.00
2.00	Land Improvements	3,022,362	0	0	0	0	2.00
3.00	Buildings and Fixtures	190,935,678	3,686,036	0	3,686,036	0	3.00
4.00	Building Improvements	1,737,035	32,749	0	32,749	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	86,291,407	4,716,509	0	4,716,509	4,309	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	283,808,114	12,055,749	0	12,055,749	4,309	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	283,808,114	12,055,749	0	12,055,749	4,309	10.00
	Ending Balance		Fully Depreciated Assets				
	6.00		7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	5,442,087	0				1.00
2.00	Land Improvements	3,022,362	0				2.00
3.00	Buildings and Fixtures	194,621,714	0				3.00
4.00	Building Improvements	1,769,784	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	91,003,607	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	295,859,554	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	295,859,554	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0128

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

Worksheet A-7
Part II
Date/Time Prepared:
5/25/2023 11:46 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	0	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	0	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	0				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	0				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0128

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

Worksheet A-7
Part III
Date/Time Prepared:
5/25/2023 11:46 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	204,855,947	0	204,855,947	0.692409	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	91,003,607	0	91,003,607	0.307591	0	2.00
3.00	Total (sum of lines 1-2)	295,859,554	0	295,859,554	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	5,227,333	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	7,560,180	3,503,883	2.00
3.00	Total (sum of lines 1-2)	0	0	0	12,787,513	3,503,883	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	1,960,361	226,433	0	0	7,414,127	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	11,064,063	2.00
3.00	Total (sum of lines 1-2)	1,960,361	226,433	0	0	18,478,190	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 15-0128

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

Worksheet A-8

Date/Time Prepared:
5/25/2023 11:46 am

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.		
			Cost Center	Line #			
			1.00	2.00			3.00
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)	B		0	ADMINISTRATIVE & GENERAL	5.00	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	-896,875				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	4,231,536				0	12.00
13.00 Laundry and linen service			0		0.00	0	13.00
14.00 Cafeteria-employees and guests	B	-1,246,265	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			0		0.00	0	18.00
19.00 Nursing and allied health education (tuition, fees, books, etc.)			0		0.00	0	19.00
20.00 Vending machines			0		0.00	0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)			0		0.00	0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments			0		0.00	0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		0	RESPIRATORY THERAPY	65.00		23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		0	PHYSICAL THERAPY	66.00		24.00
25.00 Utilization review - physicians' compensation (chapter 21)			0	*** Cost Center Deleted ***	114.00		25.00
26.00 Depreciation - CAP REL COSTS-BLDG & FIXT			0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP			0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00 Non-physician Anesthetist			0	*** Cost Center Deleted ***	19.00		28.00
29.00 Physicians' assistant			0		0.00	0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0	OCCUPATIONAL THERAPY	67.00		30.00
30.99 Hospice (non-distinct) (see instructions)			0	ADULTS & PEDIATRICS	30.00		30.99
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 Loss on Assets	A		0	OPERATING ROOM	50.00	0	33.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 15-0128

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

Worksheet A-8

Date/Time Prepared:
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Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			Wkst. A-7 Ref.
			Cost Center		Line #	
			1.00	2.00	3.00	
33.01 Misc Revenue	B	-483,653	ADMINISTRATIVE & GENERAL		5.00	0 33.01
33.02 Misc Revenue	B	-3,000	OPERATION OF PLANT		7.00	0 33.02
33.03 Misc Revenue	B	-14,880	DIETARY		10.00	0 33.03
33.04 Misc Revenue	B	-392,899	RADIOLOGY-DIAGNOSTIC		54.00	0 33.04
33.05 Misc Revenue	B	9,000	PHYSICAL THERAPY		66.00	0 33.05
33.06 Misc Revenue	B	-8,224	MEDICAL SUPPLIES CHARGED TO PATIENTS		71.00	0 33.06
33.07 Misc Revenue	B	-46,800	DRUGS CHARGED TO PATIENTS		73.00	0 33.07
33.08 Space Rental Income	B	-747,893	OPERATION OF PLANT		7.00	0 33.08
34.00 HAF Tax Offset	A	-16,616,718	ADMINISTRATIVE & GENERAL		5.00	0 34.00
34.01 PNC Non-Allow Interest Expense	A	-14,488	CAP REL COSTS-BLDG & FIXT		1.00	11 34.01
34.02 2012A Non-Allowable Interest Expense	A	-34,482	CAP REL COSTS-BLDG & FIXT		1.00	11 34.02
34.03 2012B Non-Allow Interest Expense	A	-63,787	CAP REL COSTS-BLDG & FIXT		1.00	11 34.03
34.04 2022A Non-Allow Interest Expense	A	-21,318	CAP REL COSTS-BLDG & FIXT		1.00	11 34.04
34.05 2016AB Non-Allow Interest Expense	A	-235,084	CAP REL COSTS-BLDG & FIXT		1.00	11 34.05
34.06 Non-Allow Debt Issuance Expense	A	-146,841	ADMINISTRATIVE & GENERAL		5.00	0 34.06
34.07 2018A Non-Allowable Interest Expense	A	-1,744,634	CAP REL COSTS-BLDG & FIXT		1.00	11 34.07
34.08 2020A Non-Allow Interest Expense	A	-1,228,717	CAP REL COSTS-BLDG & FIXT		1.00	11 34.08
36.00 Meals on Wheels Cost	A	-94,611	CAFETERIA		11.00	0 36.00
36.01 Hospitalist Loss	A	-5,454,431	ADULTS & PEDIATRICS		30.00	0 36.01
36.02 Bad Debt	A	-11,976,746	ADMINISTRATIVE & GENERAL		5.00	0 36.02
36.03 APP	A	-326,423	ANTI-COAGULATION CLINIC		90.02	0 36.03
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-37,558,233				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: 15-0128
 Period: From 01/01/2022 To 12/31/2022
 Worksheet A-8-1
 Date/Time Prepared: 5/25/2023 11:46 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	21.00	I&R SERVICES-SALARY & FRINGE	RESIDENTS	687,420	0 1.00
2.00	22.00	I&R SERVICES-OTHER PRGM. COS	RESIDENTS	1,455,126	0 2.00
3.00	2.00	CAP REL COSTS-MVBLE EQUIP	HOME OFFICE	2,000,398	0 3.00
3.01	4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE	4,021,999	0 3.01
3.02	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE	32,714,225	46,202,286 3.02
3.03	7.00	OPERATION OF PLANT	HOME OFFICE	2,276,122	0 3.03
3.04	13.00	NURSING ADMINISTRATION	HOME OFFICE	3,568,873	0 3.04
3.05	71.00	MEDICAL SUPPLIES CHARGED TO	HOME OFFICE	1,014,305	0 3.05
3.06	16.00	MEDICAL RECORDS & LIBRARY	HOME OFFICE	1,517,043	0 3.06
3.07	30.00	ADULTS & PEDIATRICS	HOME OFFICE	64,153	0 3.07
3.08	54.00	RADIOLOGY-DIAGNOSTIC	HOME OFFICE	189,693	0 3.08
3.09	70.00	ELECTROENCEPHALOGRAPHY	HOME OFFICE	154,488	0 3.09
3.10	73.00	DRUGS CHARGED TO PATIENTS	HOME OFFICE	163,092	0 3.10
4.00	5.00	ADMINISTRATIVE & GENERAL	CPN MEDICAL DIRECTOR	7,594	0 4.00
4.01	91.00	EMERGENCY	CPN ON CALL	599,291	0 4.01
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			50,433,822	46,202,286 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.

Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	Related Organization(s) and/or Home Office
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	C	CHNW	100.00	0.00	6.00
7.00			0.00	0.00	7.00
8.00			0.00	0.00	8.00
9.00			0.00	0.00	9.00
10.00			0.00	0.00	10.00
100.00	G. Other (financial or non-financial) specify:	OTHER			100.00

- (1) Use the following symbols to indicate interrelationship to related organizations:
- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
 - B. Corporation, partnership, or other organization has financial interest in provider.
 - C. Provider has financial interest in corporation, partnership, or other organization.
 - D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
 - E. Individual is director, officer, administrator, or key person of provider and related organization.
 - F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

Provider CCN: 15-0128

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

Worksheet A-8-1

Date/Time Prepared:
5/25/2023 11:46 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	687,420	0		1.00
2.00	1,455,126	0		2.00
3.00	2,000,398	9		3.00
3.01	4,021,999	0		3.01
3.02	-13,488,061	0		3.02
3.03	2,276,122	0		3.03
3.04	3,568,873	0		3.04
3.05	1,014,305	0		3.05
3.06	1,517,043	0		3.06
3.07	64,153	0		3.07
3.08	189,693	0		3.08
3.09	154,488	0		3.09
3.10	163,092	0		3.10
4.00	7,594	0		4.00
4.01	599,291	0		4.01
5.00	4,231,536			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 requested information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

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

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 15-0128

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

Worksheet A-8-2

Date/Time Prepared:
5/25/2023 11:46 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	5.00	AGGREGATE-ADMINISTRATIVE & GENERAL	829,675	829,675	0	0	0	1.00
2.00	50.00	AGGREGATE-OPERATING ROOM	67,200	67,200	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			896,875	896,875	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	AGGREGATE-ADMINISTRATIVE & GENERAL	0	0	0	0	0	1.00
2.00	50.00	AGGREGATE-OPERATING ROOM	0	0	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.00	AGGREGATE-ADMINISTRATIVE & GENERAL	0	0	0	829,675		1.00
2.00	50.00	AGGREGATE-OPERATING ROOM	0	0	0	67,200		2.00
3.00	0.00		0	0	0	0		3.00
4.00	0.00		0	0	0	0		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	896,875		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0128

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

Worksheet B
Part I
Date/Time Prepared:
5/25/2023 11:46 am

Cost Center Description	Net Expenses for Cost Allocation (from Wkst Allocation 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal		
		BLDG & FIXT	MVBLE EQUIP				
		0	1.00				2.00
GENERAL SERVICE COST CENTERS							
1.00 00100	CAP REL COSTS-BLDG & FIXT	7,414,127	7,414,127			1.00	
2.00 00200	CAP REL COSTS-MVBLE EQUIP	11,064,063		11,064,063		2.00	
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	4,022,005	0	0	4,022,005	4.00	
5.00 00500	ADMINISTRATIVE & GENERAL	37,733,860	373,605	140,490	179,918	5.00	
7.00 00700	OPERATION OF PLANT	6,395,169	971,051	55,227	40,266	7.00	
8.00 00800	LAUNDRY & LINEN SERVICE	676,619	20,217	0	0	8.00	
9.00 00900	HOUSEKEEPING	2,918,385	42,884	23,476	86,584	9.00	
10.00 01000	DIETARY	1,110,740	79,932	14,666	26,237	10.00	
11.00 01100	CAFETERIA	925,991	161,278	20,908	52,995	11.00	
13.00 01300	NURSING ADMINISTRATION	4,040,364	0	0	19,212	13.00	
16.00 01600	MEDICAL RECORDS & LIBRARY	1,517,043	8,445	0	0	16.00	
17.00 01700	SOCIAL SERVICE	1,789,341	19,918	2,448	72,774	17.00	
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	687,420	0	0	0	21.00	
22.00 02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	1,455,126	0	0	0	22.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000	ADULTS & PEDIATRICS	37,328,863	1,701,531	246,528	1,248,655	30.00	
31.00 03100	INTENSIVE CARE UNIT	5,234,449	539,763	173,355	202,800	31.00	
43.00 04300	NURSERY	970,721	57,683	19,100	35,141	43.00	
ANCILLARY SERVICE COST CENTERS							
50.00 05000	OPERATING ROOM	7,537,990	759,998	3,986,754	185,867	50.00	
51.00 05100	RECOVERY ROOM	4,566,992	157,254	100,033	171,226	51.00	
52.00 05200	DELIVERY ROOM & LABOR ROOM	5,535,061	290,786	96,280	208,530	52.00	
54.00 05400	RADIOLOGY-DIAGNOSTIC	2,847,199	254,156	314,900	104,366	54.00	
55.00 05500	RADIOLOGY-THERAPEUTIC	1,684,318	0	362,126	44,116	55.00	
57.00 05700	CT SCAN	2,186,412	34,140	18,541	60,128	57.00	
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	852,214	31,152	143,326	29,054	58.00	
59.00 05900	CARDIAC CATHETERIZATION	3,295,574	205,157	695,044	84,146	59.00	
60.00 06000	LABORATORY	9,092,348	96,982	0	0	60.00	
64.00 06400	INTRAVENOUS THERAPY	0	0	0	0	64.00	
65.00 06500	RESPIRATORY THERAPY	3,431,850	47,186	24,622	132,621	65.00	
66.00 06600	PHYSICAL THERAPY	3,464,397	15,337	764,516	131,460	66.00	
67.00 06700	OCCUPATIONAL THERAPY	1,047,231	4,641	28,629	40,034	67.00	
68.00 06800	SPEECH PATHOLOGY	226,699	996	6,198	8,666	68.00	
69.00 06900	ELECTROCARDIOLOGY	1,709,931	111,124	164,290	61,963	69.00	
70.00 07000	ELECTROENCEPHALOGRAPHY	977,376	46,270	168,924	27,421	70.00	
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	16,478,828	215,316	1,823,469	24,608	71.00	
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	9,572,835	0	0	0	72.00	
73.00 07300	DRUGS CHARGED TO PATIENTS	11,921,719	117,119	535,554	174,677	73.00	
74.00 07400	RENAL DIALYSIS	519,182	21,452	0	600	74.00	
76.00 03950	ENDOSCOPY	1,171,862	0	231,814	36,380	76.00	
76.06 03330	IMAGING CENTER	1,717,818	0	536,595	54,551	76.06	
76.97 07697	CARDIAC REHABILITATION	486,838	0	26,736	18,835	76.97	
OUTPATIENT SERVICE COST CENTERS							
90.00 09000	CLINIC	0	0	0	0	90.00	
90.01 04950	DIABETIC CARE CENTER	0	0	0	0	90.01	
90.02 04951	ANTI-COAGULATION CLINIC	396,050	0	956	27,224	90.02	
90.03 04952	PALLIATIVE CARE	0	0	0	0	90.03	
90.04 04953	SPINE CENTER	343,626	0	96,400	12,630	90.04	
91.00 09100	EMERGENCY	14,559,435	622,483	242,158	372,003	91.00	
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00	
SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	230,908,071	7,007,856	11,064,063	3,975,688	230,455,483	118.00
NONREIMBURSABLE COST CENTERS							
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	23,404	0	0	23,404	190.00
191.00 19100	RESEARCH	0	0	0	0	0	191.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	109,662	0	0	0	109,662	192.00
193.00 19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00 07950	HOME OFFICE	0	0	0	0	0	194.00
194.06 07956	LEASED OFFICE SPACE	0	372,012	0	0	372,012	194.06
194.08 07958	MISC NONREIMBURSABLE COST CENTERS	1,668,537	10,855	0	46,317	1,725,709	194.08
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)	232,686,270	7,414,127	11,064,063	4,022,005	232,686,270	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0128

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

Worksheet B
Part I
Date/Time Prepared:
5/25/2023 11:46 am

Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	38,427,873				5.00
7.00	00700	OPERATION OF PLANT	1,476,061	8,937,774			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	137,847	29,771	864,454		8.00
9.00	00900	HOUSEKEEPING	607,564	63,150	0	3,742,043	9.00
10.00	01000	DIETARY	243,628	117,706	0	49,798	10.00
11.00	01100	CAFETERIA	229,701	237,494	0	100,478	0 11.00
13.00	01300	NURSING ADMINISTRATION	803,057	0	0	0	0 13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	301,769	12,436	0	5,262	0 16.00
17.00	01700	SOCIAL SERVICE	372,784	29,331	0	12,409	0 17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	135,984	0	0	0	0 21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	287,850	0	0	0	0 22.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	8,016,755	2,505,638	356,217	1,060,076	1,505,009 30.00
31.00	03100	INTENSIVE CARE UNIT	1,216,653	794,844	41,892	336,279	137,698 31.00
43.00	04300	NURSERY	214,167	84,943	9,986	35,937	0 43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	2,466,911	1,119,158	84,189	473,488	0 50.00
51.00	05100	RECOVERY ROOM	988,201	231,569	46,350	97,971	0 51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,212,754	428,205	50,341	181,163	0 52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	696,442	374,265	15,182	158,342	0 54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	413,550	0	0	0	0 55.00
57.00	05700	CT SCAN	454,827	50,274	60,299	21,270	0 57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	208,846	45,874	0	19,408	0 58.00
59.00	05900	CARDIAC CATHETERIZATION	846,645	302,110	12,193	127,816	0 59.00
60.00	06000	LABORATORY	1,817,815	142,813	0	60,421	0 60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0 64.00
65.00	06500	RESPIRATORY THERAPY	719,321	69,485	0	29,398	0 65.00
66.00	06600	PHYSICAL THERAPY	865,594	22,585	0	9,555	0 66.00
67.00	06700	OCCUPATIONAL THERAPY	221,662	6,834	0	2,891	0 67.00
68.00	06800	SPEECH PATHOLOGY	47,983	1,467	0	620	0 68.00
69.00	06900	ELECTROCARDIOLOGY	404,994	163,638	0	69,231	0 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	241,336	68,136	0	28,827	0 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,667,985	317,069	0	134,144	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,893,679	0	0	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,521,995	172,467	0	72,967	0 73.00
74.00	07400	RENAL DIALYSIS	107,066	31,590	0	13,365	0 74.00
76.00	03950	ENDOSCOPY	284,869	0	0	0	0 76.00
76.06	03330	IMAGING CENTER	456,755	0	0	0	0 76.06
76.97	07697	CARDIAC REHABILITATION	105,320	0	0	0	0 76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	0 90.00
90.01	04950	DIABETIC CARE CENTER	0	0	0	0	0 90.01
90.02	04951	ANTI-COAGULATION CLINIC	83,920	0	0	0	0 90.02
90.03	04952	PALLIATIVE CARE	0	0	0	0	0 90.03
90.04	04953	SPINE CENTER	89,544	0	0	0	0 90.04
91.00	09100	EMERGENCY	3,124,749	916,656	187,805	387,815	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	37,986,583	8,339,508	864,454	3,488,931	1,642,707 118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	4,630	34,464	0	14,581	0 190.00
191.00	19100	RESEARCH	0	0	0	0	0 191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	21,693	0	0	0	0 192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0 193.00
194.00	07950	HOME OFFICE	0	0	0	0	0 194.00
194.06	07956	LEASED OFFICE SPACE	73,591	547,817	0	231,768	0 194.06
194.08	07958	MISC NONREIMBURSABLE COST CENTERS	341,376	15,985	0	6,763	0 194.08
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)	38,427,873	8,937,774	864,454	3,742,043	1,642,707 202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0128

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

Worksheet B
Part I
Date/Time Prepared:
5/25/2023 11:46 am

Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	INTERNS & RESIDENTS		
					SERVICES-SALARY & FRINGES		
	11.00	13.00	16.00	17.00	21.00		
GENERAL SERVICE COST CENTERS							
1.00 00100 CAP REL COSTS-BLDG & FIXT						1.00	
2.00 00200 CAP REL COSTS-MVBLE EQUIP						2.00	
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00	
5.00 00500 ADMINISTRATIVE & GENERAL						5.00	
7.00 00700 OPERATION OF PLANT						7.00	
8.00 00800 LAUNDRY & LINEN SERVICE						8.00	
9.00 00900 HOUSEKEEPING						9.00	
10.00 01000 DIETARY						10.00	
11.00 01100 CAFETERIA	1,728,845					11.00	
13.00 01300 NURSING ADMINISTRATION	21,731	4,884,364				13.00	
16.00 01600 MEDICAL RECORDS & LIBRARY	0	0	1,844,955			16.00	
17.00 01700 SOCIAL SERVICE	38,633	0	0	2,337,638		17.00	
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	823,404	21.00	
22.00 02200 I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	0	0	0	0	22.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000 ADULTS & PEDIATRICS	615,719	3,326,716	224,104	2,029,445	514,082	30.00	
31.00 03100 INTENSIVE CARE UNIT	77,267	414,969	26,629	178,138	18,516	31.00	
43.00 04300 NURSERY	16,902	93,759	6,324	130,055	0	43.00	
ANCILLARY SERVICE COST CENTERS							
50.00 05000 OPERATING ROOM	118,315	0	227,920	0	165,552	50.00	
51.00 05100 RECOVERY ROOM	84,511	0	60,646	0	0	51.00	
52.00 05200 DELIVERY ROOM & LABOR ROOM	86,925	0	31,879	0	0	52.00	
54.00 05400 RADIOLOGY-DIAGNOSTIC	55,536	0	69,788	0	0	54.00	
55.00 05500 RADIOLOGY-THERAPEUTIC	21,731	0	39,545	0	0	55.00	
57.00 05700 CT SCAN	33,804	0	139,439	0	0	57.00	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	16,902	0	27,426	0	0	58.00	
59.00 05900 CARDIAC CATHETERIZATION	38,633	0	200,868	0	18,516	59.00	
60.00 06000 LABORATORY	0	0	101,930	0	0	60.00	
64.00 06400 INTRAVENOUS THERAPY	0	0	0	0	0	64.00	
65.00 06500 RESPIRATORY THERAPY	57,950	0	35,428	0	0	65.00	
66.00 06600 PHYSICAL THERAPY	31,390	0	18,811	0	25,051	66.00	
67.00 06700 OCCUPATIONAL THERAPY	21,731	0	5,926	21,731	0	67.00	
68.00 06800 SPEECH PATHOLOGY	4,829	0	1,282	0	0	68.00	
69.00 06900 ELECTROCARDIOLOGY	43,463	0	42,690	0	0	69.00	
70.00 07000 ELECTROENCEPHALOGRAPHY	14,488	0	11,556	0	0	70.00	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	24,146	0	60,770	0	0	71.00	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	55,838	0	0	72.00	
73.00 07300 DRUGS CHARGED TO PATIENTS	77,267	0	101,479	0	0	73.00	
74.00 07400 RENAL DIALYSIS	0	0	3,913	0	0	74.00	
76.00 03950 ENDOSCOPY	16,902	0	17,418	0	0	76.00	
76.06 03330 IMAGING CENTER	2,415	0	31,402	0	0	76.06	
76.97 07697 CARDIAC REHABILITATION	14,488	0	4,098	0	0	76.97	
OUTPATIENT SERVICE COST CENTERS							
90.00 09000 CLINIC	0	0	0	0	0	90.00	
90.01 04950 DIABETIC CARE CENTER	0	0	0	0	0	90.01	
90.02 04951 ANTI-COAGULATION CLINIC	0	0	3,034	0	0	90.02	
90.03 04952 PALLIATIVE CARE	0	0	0	0	0	90.03	
90.04 04953 SPINE CENTER	0	0	805	0	8,713	90.04	
91.00 09100 EMERGENCY	193,167	1,048,920	294,007	0	72,974	91.00	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00	
SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	1,728,845	4,884,364	1,844,955	2,337,638	823,404	118.00
NONREIMBURSABLE COST CENTERS							
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00	
191.00 19100 RESEARCH	0	0	0	0	0	191.00	
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00	
193.00 19300 NONPAID WORKERS	0	0	0	0	0	193.00	
194.00 07950 HOME OFFICE	0	0	0	0	0	194.00	
194.06 07956 LEASED OFFICE SPACE	0	0	0	0	0	194.06	
194.08 07958 MISC NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.08	
200.00	Cross Foot Adjustments	0	0	0	0	200.00	
201.00	Negative Cost Centers	0	0	0	0	201.00	
202.00	TOTAL (sum lines 118 through 201)	1,728,845	4,884,364	1,844,955	2,337,638	823,404	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0128

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

Worksheet B
Part I
Date/Time Prepared:
5/25/2023 11:46 am

Cost Center Description		INTERNS & RESIDENTS SERVICES-OTHER PRGM. COSTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		22.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE				17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD				21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	1,742,976			22.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,088,207	61,767,545	-1,602,289	60,165,256
31.00	03100	INTENSIVE CARE UNIT	39,194	9,432,446	-57,710	9,374,736
43.00	04300	NURSERY	0	1,674,718	0	1,674,718
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	350,440	17,476,582	-515,992	16,960,590
51.00	05100	RECOVERY ROOM	0	6,504,753	0	6,504,753
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	8,121,924	0	8,121,924
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	4,890,176	0	4,890,176
55.00	05500	RADIOLOGY-THERAPEUTIC	0	2,565,386	0	2,565,386
57.00	05700	CT SCAN	0	3,059,134	0	3,059,134
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	1,374,202	0	1,374,202
59.00	05900	CARDIAC CATHETERIZATION	39,194	5,865,896	-57,710	5,808,186
60.00	06000	LABORATORY	0	11,312,309	0	11,312,309
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	0	4,547,861	0	4,547,861
66.00	06600	PHYSICAL THERAPY	53,027	5,401,723	-78,078	5,323,645
67.00	06700	OCCUPATIONAL THERAPY	0	1,379,579	0	1,379,579
68.00	06800	SPEECH PATHOLOGY	0	298,740	0	298,740
69.00	06900	ELECTROCARDIOLOGY	0	2,771,324	0	2,771,324
70.00	07000	ELECTROENCEPHALOGRAPHY	0	1,584,334	0	1,584,334
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	22,746,335	0	22,746,335
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	11,522,352	0	11,522,352
73.00	07300	DRUGS CHARGED TO PATIENTS	0	15,695,244	0	15,695,244
74.00	07400	RENAL DIALYSIS	0	697,168	0	697,168
76.00	03950	ENDOSCOPY	0	1,759,245	0	1,759,245
76.06	03330	IMAGING CENTER	0	2,799,536	0	2,799,536
76.97	07697	CARDIAC REHABILITATION	0	656,315	0	656,315
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0
90.01	04950	DIABETIC CARE CENTER	0	0	0	0
90.02	04951	ANTI-COAGULATION CLINIC	0	511,184	0	511,184
90.03	04952	PALLIATIVE CARE	0	0	0	0
90.04	04953	SPINE CENTER	18,444	570,162	-27,157	543,005
91.00	09100	EMERGENCY	154,470	22,176,642	-227,444	21,949,198
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0
SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,742,976	229,162,815	-2,566,380	226,596,435
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	77,079	0	77,079
191.00	19100	RESEARCH	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	131,355	0	131,355
193.00	19300	NONPAID WORKERS	0	0	0	0
194.00	07950	HOME OFFICE	0	0	0	0
194.06	07956	LEASED OFFICE SPACE	0	1,225,188	0	1,225,188
194.08	07958	MISC NONREIMBURSABLE COST CENTERS	0	2,089,833	0	2,089,833
200.00		Cross Foot Adjustments	0	0	0	0
201.00		Negative Cost Centers	0	0	0	0
202.00		TOTAL (sum lines 118 through 201)	1,742,976	232,686,270	-2,566,380	230,119,890

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-0128	Period: From 01/01/2022 To 12/31/2022	Worksheet B Part II Date/Time Prepared: 5/25/2023 11:46 am
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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT
		BLDG & FIXT	MVBLE EQUIP		
		0	1.00		
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	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	0	373,605	140,490	5.00
7.00 00700	OPERATION OF PLANT	0	971,051	55,227	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	20,217	0	8.00
9.00 00900	HOUSEKEEPING	0	42,884	23,476	9.00
10.00 01000	DIETARY	0	79,932	14,666	10.00
11.00 01100	CAFETERIA	0	161,278	20,908	11.00
13.00 01300	NURSING ADMINISTRATION	0	0	0	13.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	8,445	0	16.00
17.00 01700	SOCIAL SERVICE	0	19,918	2,448	17.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	21.00
22.00 02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00 03000	ADULTS & PEDIATRICS	0	1,701,531	246,528	30.00
31.00 03100	INTENSIVE CARE UNIT	0	539,763	173,355	31.00
43.00 04300	NURSERY	0	57,683	19,100	43.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000	OPERATING ROOM	0	759,998	3,986,754	50.00
51.00 05100	RECOVERY ROOM	0	157,254	100,033	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	290,786	96,280	52.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	254,156	314,900	54.00
55.00 05500	RADIOLOGY-THERAPEUTIC	0	0	362,126	55.00
57.00 05700	CT SCAN	0	34,140	18,541	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	31,152	143,326	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	205,157	695,044	59.00
60.00 06000	LABORATORY	0	96,982	0	60.00
64.00 06400	INTRAVENOUS THERAPY	0	0	0	64.00
65.00 06500	RESPIRATORY THERAPY	0	47,186	24,622	65.00
66.00 06600	PHYSICAL THERAPY	0	15,337	764,516	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	4,641	28,629	67.00
68.00 06800	SPEECH PATHOLOGY	0	996	6,198	68.00
69.00 06900	ELECTROCARDIOLOGY	0	111,124	164,290	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	46,270	168,924	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	215,316	1,823,469	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	117,119	535,554	73.00
74.00 07400	RENAL DIALYSIS	0	21,452	0	74.00
76.00 03950	ENDOSCOPY	0	0	231,814	76.00
76.06 03330	IMAGING CENTER	0	0	536,595	76.06
76.97 07697	CARDIAC REHABILITATION	0	0	26,736	76.97
OUTPATIENT SERVICE COST CENTERS					
90.00 09000	CLINIC	0	0	0	90.00
90.01 04950	DIABETIC CARE CENTER	0	0	0	90.01
90.02 04951	ANTI-COAGULATION CLINIC	0	0	956	90.02
90.03 04952	PALLIATIVE CARE	0	0	0	90.03
90.04 04953	SPINE CENTER	0	0	96,400	90.04
91.00 09100	EMERGENCY	0	622,483	242,158	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS					
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	0	7,007,856	11,064,063	118.00
NONREIMBURSABLE COST CENTERS					
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	23,404	0	190.00
191.00 19100	RESEARCH	0	0	0	191.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	192.00
193.00 19300	NONPAID WORKERS	0	0	0	193.00
194.00 07950	HOME OFFICE	0	0	0	194.00
194.06 07956	LEASED OFFICE SPACE	0	372,012	0	194.06
194.08 07958	MISC NONREIMBURSABLE COST CENTERS	0	10,855	0	194.08
200.00	Cross Foot Adjustments				200.00
201.00	Negative Cost Centers				201.00
202.00	TOTAL (sum lines 118 through 201)	0	7,414,127	11,064,063	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0128

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

Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	514,095				5.00
7.00	00700	OPERATION OF PLANT	19,744	1,046,022			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,844	3,484	25,545		8.00
9.00	00900	HOUSEKEEPING	8,127	7,391	0	81,878	9.00
10.00	01000	DIETARY	3,259	13,776	0	1,090	112,723
11.00	01100	CAFETERIA	3,072	27,795	0	2,199	0
13.00	01300	NURSING ADMINISTRATION	10,742	0	0	0	0
16.00	01600	MEDICAL RECORDS & LIBRARY	4,036	1,455	0	115	0
17.00	01700	SOCIAL SERVICE	4,986	3,433	0	272	0
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	1,819	0	0	0	0
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	3,850	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	107,315	293,245	10,525	23,193	103,274
31.00	03100	INTENSIVE CARE UNIT	16,274	93,024	1,238	7,358	9,449
43.00	04300	NURSERY	2,865	9,941	295	786	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	32,997	130,979	2,488	10,360	0
51.00	05100	RECOVERY ROOM	13,218	27,101	1,370	2,144	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	16,222	50,114	1,488	3,964	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,316	43,802	449	3,465	0
55.00	05500	RADIOLOGY-THERAPEUTIC	5,532	0	0	0	0
57.00	05700	CT SCAN	6,084	5,884	1,782	465	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	2,794	5,369	0	425	0
59.00	05900	CARDIAC CATHETERIZATION	11,325	35,357	360	2,797	0
60.00	06000	LABORATORY	24,315	16,714	0	1,322	0
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	9,622	8,132	0	643	0
66.00	06600	PHYSICAL THERAPY	11,578	2,643	0	209	0
67.00	06700	OCCUPATIONAL THERAPY	2,965	800	0	63	0
68.00	06800	SPEECH PATHOLOGY	642	172	0	14	0
69.00	06900	ELECTROCARDIOLOGY	5,417	19,151	0	1,515	0
70.00	07000	ELECTROENCEPHALOGRAPHY	3,228	7,974	0	631	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	49,063	37,108	0	2,935	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	25,330	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	33,734	20,184	0	1,597	0
74.00	07400	RENAL DIALYSIS	1,432	3,697	0	292	0
76.00	03950	ENDOSCOPY	3,810	0	0	0	0
76.06	03330	IMAGING CENTER	6,110	0	0	0	0
76.97	07697	CARDIAC REHABILITATION	1,409	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	0
90.01	04950	DIABETIC CARE CENTER	0	0	0	0	0
90.02	04951	ANTI-COAGULATION CLINIC	1,123	0	0	0	0
90.03	04952	PALLIATIVE CARE	0	0	0	0	0
90.04	04953	SPINE CENTER	1,198	0	0	0	0
91.00	09100	EMERGENCY	41,796	107,280	5,550	8,486	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	508,193	976,005	25,545	76,340	112,723
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	62	4,033	0	319	0
191.00	19100	RESEARCH	0	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	290	0	0	0	0
193.00	19300	NONPAID WORKERS	0	0	0	0	0
194.00	07950	HOME OFFICE	0	0	0	0	0
194.06	07956	LEASED OFFICE SPACE	984	64,113	0	5,071	0
194.08	07958	MISC NONREIMBURSABLE COST CENTERS	4,566	1,871	0	148	0
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118 through 201)	514,095	1,046,022	25,545	81,878	112,723

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-0128	Period: From 01/01/2022 To 12/31/2022	Worksheet B Part II Date/Time Prepared: 5/25/2023 11:46 am		
Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	INTERNS & RESIDENTS SERVICES-SALAR Y & FRINGES
		11.00	13.00	16.00	17.00	21.00
GENERAL SERVICE COST CENTERS						
1.00	00100					1.00
2.00	00200					2.00
4.00	00400					4.00
5.00	00500					5.00
7.00	00700					7.00
8.00	00800					8.00
9.00	00900					9.00
10.00	01000					10.00
11.00	01100	215,252				11.00
13.00	01300	2,706	13,448			13.00
16.00	01600	0	0	14,051		16.00
17.00	01700	4,810	0	0	35,867	17.00
21.00	02100	0	0	0	0	21.00
22.00	02200	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	76,661	9,159	1,736	31,139	30.00
31.00	03100	9,620	1,143	206	2,733	31.00
43.00	04300	2,104	258	49	1,995	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	14,731	0	1,766	0	50.00
51.00	05100	10,522	0	470	0	51.00
52.00	05200	10,823	0	247	0	52.00
54.00	05400	6,915	0	541	0	54.00
55.00	05500	2,706	0	306	0	55.00
57.00	05700	4,209	0	1,080	0	57.00
58.00	05800	2,104	0	212	0	58.00
59.00	05900	4,810	0	1,556	0	59.00
60.00	06000	0	0	790	0	60.00
64.00	06400	0	0	0	0	64.00
65.00	06500	7,215	0	274	0	65.00
66.00	06600	3,908	0	146	0	66.00
67.00	06700	2,706	0	46	0	67.00
68.00	06800	601	0	10	0	68.00
69.00	06900	5,411	0	331	0	69.00
70.00	07000	1,804	0	90	0	70.00
71.00	07100	3,006	0	471	0	71.00
72.00	07200	0	0	433	0	72.00
73.00	07300	9,620	0	786	0	73.00
74.00	07400	0	0	30	0	74.00
76.00	03950	2,104	0	135	0	76.00
76.06	03330	301	0	243	0	76.06
76.97	07697	1,804	0	32	0	76.97
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	0	0	0	0	90.00
90.01	04950	0	0	0	0	90.01
90.02	04951	0	0	24	0	90.02
90.03	04952	0	0	0	0	90.03
90.04	04953	0	0	6	0	90.04
91.00	09100	24,051	2,888	2,035	0	91.00
92.00	09200					92.00
SPECIAL PURPOSE COST CENTERS						
118.00		215,252	13,448	14,051	35,867	0
NONREIMBURSABLE COST CENTERS						
190.00	19000	0	0	0	0	190.00
191.00	19100	0	0	0	0	191.00
192.00	19200	0	0	0	0	192.00
193.00	19300	0	0	0	0	193.00
194.00	07950	0	0	0	0	194.00
194.06	07956	0	0	0	0	194.06
194.08	07958	0	0	0	0	194.08
200.00						1,819
201.00		0	0	0	0	0
202.00		215,252	13,448	14,051	35,867	1,819

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 15-0128	Period: From 01/01/2022 To 12/31/2022	Worksheet B Part II Date/Time Prepared: 5/25/2023 11:46 am
Cost Center Description	INTERNS & RESIDENTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
	SERVICES-OTHER PRGM. COSTS				
	22.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE			17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD			21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	3,850		22.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	2,604,306	0	30.00
31.00	03100	INTENSIVE CARE UNIT	854,163	0	31.00
43.00	04300	NURSERY	95,076	0	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	4,940,073	0	50.00
51.00	05100	RECOVERY ROOM	312,112	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	469,924	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	633,544	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	370,670	0	55.00
57.00	05700	CT SCAN	72,185	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	185,382	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	956,406	0	59.00
60.00	06000	LABORATORY	140,123	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	97,694	0	65.00
66.00	06600	PHYSICAL THERAPY	798,337	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	39,850	0	67.00
68.00	06800	SPEECH PATHOLOGY	8,633	0	68.00
69.00	06900	ELECTROCARDIOLOGY	307,239	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	228,921	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,131,368	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	25,763	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	718,594	0	73.00
74.00	07400	RENAL DIALYSIS	26,903	0	74.00
76.00	03950	ENDOSCOPY	237,863	0	76.00
76.06	03330	IMAGING CENTER	543,249	0	76.06
76.97	07697	CARDIAC REHABILITATION	29,981	0	76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	90.00
90.01	04950	DIABETIC CARE CENTER	0	0	90.01
90.02	04951	ANTI-COAGULATION CLINIC	2,103	0	90.02
90.03	04952	PALLIATIVE CARE	0	0	90.03
90.04	04953	SPINE CENTER	97,604	0	90.04
91.00	09100	EMERGENCY	1,056,727	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	17,984,793	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	27,818	0	190.00
191.00	19100	RESEARCH	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	290	0	192.00
193.00	19300	NONPAID WORKERS	0	0	193.00
194.00	07950	HOME OFFICE	0	0	194.00
194.06	07956	LEASED OFFICE SPACE	442,180	0	194.06
194.08	07958	MISC NONREIMBURSABLE COST CENTERS	17,440	0	194.08
200.00		Cross Foot Adjustments	3,850	5,669	200.00
201.00		Negative Cost Centers	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	3,850	18,478,190	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0128

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

Worksheet B-1
Date/Time Prepared:
5/25/2023 11:46 am

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
	1.00	2.00				
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	372,229				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		8,335,244			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	78,855,435		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	18,757	105,840	3,527,454	-38,427,873	5.00
7.00 00700	OPERATION OF PLANT	48,752	41,606	789,459	0	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	1,015	0	0	0	8.00
9.00 00900	HOUSEKEEPING	2,153	17,686	1,697,566	0	9.00
10.00 01000	DIETARY	4,013	11,049	514,392	0	10.00
11.00 01100	CAFETERIA	8,097	15,751	1,039,024	0	11.00
13.00 01300	NURSING ADMINISTRATION	0	0	376,675	0	13.00
16.00 01600	MEDICAL RECORDS & LIBRARY	424	0	0	0	16.00
17.00 01700	SOCIAL SERVICE	1,000	1,844	1,426,794	0	17.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	21.00
22.00 02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	85,426	185,725	24,481,322	0	30.00
31.00 03100	INTENSIVE CARE UNIT	27,099	130,599	3,976,086	0	31.00
43.00 04300	NURSERY	2,896	14,389	688,962	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	38,156	3,003,469	3,644,102	0	50.00
51.00 05100	RECOVERY ROOM	7,895	75,361	3,357,053	0	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	14,599	72,534	4,088,419	0	52.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	12,760	237,234	2,046,201	0	54.00
55.00 05500	RADIOLOGY-THERAPEUTIC	0	272,812	864,931	0	55.00
57.00 05700	CT SCAN	1,714	13,968	1,178,872	0	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	1,564	107,976	569,636	0	58.00
59.00 05900	CARDIAC CATHETERIZATION	10,300	523,620	1,649,756	0	59.00
60.00 06000	LABORATORY	4,869	0	0	0	60.00
64.00 06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00 06500	RESPIRATORY THERAPY	2,369	18,549	2,600,156	0	65.00
66.00 06600	PHYSICAL THERAPY	770	575,957	2,577,390	0	66.00
67.00 06700	OCCUPATIONAL THERAPY	233	21,568	784,897	0	67.00
68.00 06800	SPEECH PATHOLOGY	50	4,669	169,910	0	68.00
69.00 06900	ELECTROCARDIOLOGY	5,579	123,770	1,214,847	0	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	2,323	127,261	537,613	0	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	10,810	1,373,732	482,469	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	5,880	403,466	3,424,710	0	73.00
74.00 07400	RENAL DIALYSIS	1,077	0	11,756	0	74.00
76.00 03950	ENDOSCOPY	0	174,640	713,262	0	76.00
76.06 03330	IMAGING CENTER	0	404,250	1,069,523	0	76.06
76.97 07697	CARDIAC REHABILITATION	0	20,142	369,272	0	76.97
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	0	0	0	90.00
90.01 04950	DIABETIC CARE CENTER	0	0	0	0	90.01
90.02 04951	ANTI-COAGULATION CLINIC	0	720	533,758	0	90.02
90.03 04952	PALLIATIVE CARE	0	0	0	0	90.03
90.04 04953	SPINE CENTER	0	72,624	247,617	0	90.04
91.00 09100	EMERGENCY	31,252	182,433	7,293,460	0	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	351,832	8,335,244	77,947,344	-38,427,873	192,027,610
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,175	0	0	0	23,404
191.00 19100	RESEARCH	0	0	0	0	0
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	109,662
193.00 19300	NONPAID WORKERS	0	0	0	0	0
194.00 07950	HOME OFFICE	0	0	0	0	0
194.06 07956	LEASED OFFICE SPACE	18,677	0	0	0	372,012
194.08 07958	MISC NONREIMBURSABLE COST CENTERS	545	0	908,091	0	1,725,709
200.00	Cross Foot Adjustments					
201.00	Negative Cost Centers					
202.00	Cost to be allocated (per Wkst. B, Part I)	7,414,127	11,064,063	4,022,005		38,427,873
203.00	Unit cost multiplier (Wkst. B, Part I)	19.918187	1.327383	0.051005		0.197818
204.00	Cost to be allocated (per Wkst. B, Part II)			0		514,095

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0128

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

Worksheet B-1
Date/Time Prepared:
5/25/2023 11:46 am

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
	1.00	2.00				
205.00	Unit cost multiplier (Wkst. B, Part II)					205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)		0.000000		0.002646	206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)					207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0128

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

Worksheet B-1
Date/Time Prepared:
5/25/2023 11:46 am

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	CAFETERIA (ONSITE FTES)	
		7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT	304,720				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,015	153,568			8.00
9.00	00900	HOUSEKEEPING	2,153	0	301,552		9.00
10.00	01000	DIETARY	4,013	0	4,013	36,684	10.00
11.00	01100	CAFETERIA	8,097	0	8,097	0	716
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	9
16.00	01600	MEDICAL RECORDS & LIBRARY	424	0	424	0	0
17.00	01700	SOCIAL SERVICE	1,000	0	1,000	0	16
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	85,426	63,281	85,426	33,609	255
31.00	03100	INTENSIVE CARE UNIT	27,099	7,442	27,099	3,075	32
43.00	04300	NURSERY	2,896	1,774	2,896	0	7
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	38,156	14,956	38,156	0	49
51.00	05100	RECOVERY ROOM	7,895	8,234	7,895	0	35
52.00	05200	DELIVERY ROOM & LABOR ROOM	14,599	8,943	14,599	0	36
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,760	2,697	12,760	0	23
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	9
57.00	05700	CT SCAN	1,714	10,712	1,714	0	14
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,564	0	1,564	0	7
59.00	05900	CARDIAC CATHETERIZATION	10,300	2,166	10,300	0	16
60.00	06000	LABORATORY	4,869	0	4,869	0	0
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	2,369	0	2,369	0	24
66.00	06600	PHYSICAL THERAPY	770	0	770	0	13
67.00	06700	OCCUPATIONAL THERAPY	233	0	233	0	9
68.00	06800	SPEECH PATHOLOGY	50	0	50	0	2
69.00	06900	ELECTROCARDIOLOGY	5,579	0	5,579	0	18
70.00	07000	ELECTROENCEPHALOGRAPHY	2,323	0	2,323	0	6
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	10,810	0	10,810	0	10
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	5,880	0	5,880	0	32
74.00	07400	RENAL DIALYSIS	1,077	0	1,077	0	0
76.00	03950	ENDOSCOPY	0	0	0	0	7
76.06	03330	IMAGING CENTER	0	0	0	0	1
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	6
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	0
90.01	04950	DIABETIC CARE CENTER	0	0	0	0	0
90.02	04951	ANTI-COAGULATION CLINIC	0	0	0	0	0
90.03	04952	PALLIATIVE CARE	0	0	0	0	0
90.04	04953	SPIRE CENTER	0	0	0	0	0
91.00	09100	EMERGENCY	31,252	33,363	31,252	0	80
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	284,323	153,568	281,155	36,684	716
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,175	0	1,175	0	0
191.00	19100	RESEARCH	0	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
193.00	19300	NONPAID WORKERS	0	0	0	0	0
194.00	07950	HOME OFFICE	0	0	0	0	0
194.06	07956	LEASED OFFICE SPACE	18,677	0	18,677	0	0
194.08	07958	MISC NONREIMBURSABLE COST CENTERS	545	0	545	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers					
202.00		Cost to be allocated (per Wkst. B, Part I)	8,937,774	864,454	3,742,043	1,642,707	1,728,845
203.00		Unit cost multiplier (Wkst. B, Part I)	29.331104	5.629128	12.409279	44.779931	2,414.587989
204.00		Cost to be allocated (per Wkst. B, Part II)	1,046,022	25,545	81,878	112,723	215,252
205.00		Unit cost multiplier (Wkst. B, Part II)	3.432732	0.166343	0.271522	3.072811	300.631285
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)					

COST ALLOCATION - STATISTICAL BASIS		Provider CCN: 15-0128			Period: From 01/01/2022 To 12/31/2022		Worksheet B-1 Date/Time Prepared: 5/25/2023 11:46 am	
Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	CAFETERIA (ONSITE FTES)		
		7.00	8.00	9.00	10.00	11.00		
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)							207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0128

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

Worksheet B-1
Date/Time Prepared:
5/25/2023 11:46 am

Cost Center Description	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TOTAL PATIENT DAYS)	INTERNS & RESIDENTS			
				SERVICES-SALARY & FRINGES (ASSIGNED TIME)	SERVICES-OTHER PRGM. COSTS (ASSIGNED TIME)		
				13.00	16.00		17.00
GENERAL SERVICE COST CENTERS							
1.00 00100 CAP REL COSTS-BLDG & FIXT						1.00	
2.00 00200 CAP REL COSTS-MVBLE EQUIP						2.00	
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00	
5.00 00500 ADMINISTRATIVE & GENERAL						5.00	
7.00 00700 OPERATION OF PLANT						7.00	
8.00 00800 LAUNDRY & LINEN SERVICE						8.00	
9.00 00900 HOUSEKEEPING						9.00	
10.00 01000 DIETARY						10.00	
11.00 01100 CAFETERIA						11.00	
13.00 01300 NURSING ADMINISTRATION	777,567					13.00	
16.00 01600 MEDICAL RECORDS & LIBRARY	0	1,099,509,471				16.00	
17.00 01700 SOCIAL SERVICE	0	0	40,352			17.00	
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	75,600		21.00	
22.00 02200 I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	0	0	0	75,600	22.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000 ADULTS & PEDIATRICS	529,597	133,554,242	35,032	47,200	47,200	30.00	
31.00 03100 INTENSIVE CARE UNIT	66,061	15,869,571	3,075	1,700	1,700	31.00	
43.00 04300 NURSERY	14,926	3,768,840	2,245	0	0	43.00	
ANCILLARY SERVICE COST CENTERS							
50.00 05000 OPERATING ROOM	0	135,828,221	0	15,200	15,200	50.00	
51.00 05100 RECOVERY ROOM	0	36,141,765	0	0	0	51.00	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	18,998,039	0	0	0	52.00	
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	41,589,935	0	0	0	54.00	
55.00 05500 RADIOLOGY-THERAPEUTIC	0	23,566,966	0	0	0	55.00	
57.00 05700 CT SCAN	0	83,098,486	0	0	0	57.00	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	16,344,634	0	0	0	58.00	
59.00 05900 CARDIAC CATHETERIZATION	0	119,706,900	0	1,700	1,700	59.00	
60.00 06000 LABORATORY	0	60,745,042	0	0	0	60.00	
64.00 06400 INTRAVENOUS THERAPY	0	0	0	0	0	64.00	
65.00 06500 RESPIRATORY THERAPY	0	21,113,253	0	0	0	65.00	
66.00 06600 PHYSICAL THERAPY	0	11,210,103	0	2,300	2,300	66.00	
67.00 06700 OCCUPATIONAL THERAPY	0	3,531,453	0	0	0	67.00	
68.00 06800 SPEECH PATHOLOGY	0	764,291	0	0	0	68.00	
69.00 06900 ELECTROCARDIOLOGY	0	25,440,900	0	0	0	69.00	
70.00 07000 ELECTROENCEPHALOGRAPHY	0	6,886,961	0	0	0	70.00	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	36,215,592	0	0	0	71.00	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	33,276,427	0	0	0	72.00	
73.00 07300 DRUGS CHARGED TO PATIENTS	0	60,476,297	0	0	0	73.00	
74.00 07400 RENAL DIALYSIS	0	2,332,228	0	0	0	74.00	
76.00 03950 ENDOSCOPY	0	10,380,109	0	0	0	76.00	
76.06 03330 IMAGING CENTER	0	18,713,653	0	0	0	76.06	
76.97 07697 CARDIAC REHABILITATION	0	2,442,475	0	0	0	76.97	
OUTPATIENT SERVICE COST CENTERS							
90.00 09000 CLINIC	0	0	0	0	0	90.00	
90.01 04950 DIABETIC CARE CENTER	0	0	0	0	0	90.01	
90.02 04951 ANTI-COAGULATION CLINIC	0	1,807,877	0	0	0	90.02	
90.03 04952 PALLIATIVE CARE	0	0	0	0	0	90.03	
90.04 04953 SPINE CENTER	0	479,680	0	800	800	90.04	
91.00 09100 EMERGENCY	166,983	175,225,531	0	6,700	6,700	91.00	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00	
SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	777,567	1,099,509,471	40,352	75,600	75,600	118.00
NONREIMBURSABLE COST CENTERS							
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00	
191.00 19100 RESEARCH	0	0	0	0	0	191.00	
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00	
193.00 19300 NONPAID WORKERS	0	0	0	0	0	193.00	
194.00 07950 HOME OFFICE	0	0	0	0	0	194.00	
194.06 07956 LEASED OFFICE SPACE	0	0	0	0	0	194.06	
194.08 07958 MISC NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.08	
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)	4,884,364	1,844,955	2,337,638	823,404	1,742,976	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	6.281599	0.001678	57.931156	10.891587	23.055238	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	13,448	14,051	35,867	1,819	3,850	204.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0128

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

Worksheet B-1

Date/Time Prepared:
5/25/2023 11:46 am

Cost Center Description	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TOTAL PATIENT DAYS)	INTERNS & RESIDENTS			
				SERVICES-SALAR Y & FRINGES (ASSIGNED TIME)	SERVICES-OTHER PRGM. COSTS (ASSIGNED TIME)		
				13.00	16.00		17.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.017295	0.000013	0.888853	0.024061	0.050926	205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0128

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

Worksheet C
Part I
Date/Time Prepared:
5/25/2023 11:46 am

		Title XVIII		Hospital		PPS	
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
			Total Costs	RCE Disallowance	Total Costs		
	1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS		60,165,256	0	60,165,256	30.00	
31.00	03100 INTENSIVE CARE UNIT		9,374,736	0	9,374,736	31.00	
43.00	04300 NURSERY		1,674,718	0	1,674,718	43.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM		16,960,590	0	16,960,590	50.00	
51.00	05100 RECOVERY ROOM		6,504,753	0	6,504,753	51.00	
52.00	05200 DELIVERY ROOM & LABOR ROOM		8,121,924	0	8,121,924	52.00	
54.00	05400 RADIOLOGY-DIAGNOSTIC		4,890,176	0	4,890,176	54.00	
55.00	05500 RADIOLOGY-THERAPEUTIC		2,565,386	0	2,565,386	55.00	
57.00	05700 CT SCAN		3,059,134	0	3,059,134	57.00	
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)		1,374,202	0	1,374,202	58.00	
59.00	05900 CARDIAC CATHETERIZATION		5,808,186	0	5,808,186	59.00	
60.00	06000 LABORATORY		11,312,309	0	11,312,309	60.00	
64.00	06400 INTRAVENOUS THERAPY		0	0	0	64.00	
65.00	06500 RESPIRATORY THERAPY	0	4,547,861	0	4,547,861	65.00	
66.00	06600 PHYSICAL THERAPY	0	5,323,645	0	5,323,645	66.00	
67.00	06700 OCCUPATIONAL THERAPY	0	1,379,579	0	1,379,579	67.00	
68.00	06800 SPEECH PATHOLOGY	0	298,740	0	298,740	68.00	
69.00	06900 ELECTROCARDIOLOGY		2,771,324	0	2,771,324	69.00	
70.00	07000 ELECTROENCEPHALOGRAPHY		1,584,334	0	1,584,334	70.00	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		22,746,335	0	22,746,335	71.00	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		11,522,352	0	11,522,352	72.00	
73.00	07300 DRUGS CHARGED TO PATIENTS		15,695,244	0	15,695,244	73.00	
74.00	07400 RENAL DIALYSIS		697,168	0	697,168	74.00	
76.00	03950 ENDOSCOPY		1,759,245	0	1,759,245	76.00	
76.06	03330 IMAGING CENTER		2,799,536	0	2,799,536	76.06	
76.97	07697 CARDIAC REHABILITATION		656,315	0	656,315	76.97	
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC		0	0	0	90.00	
90.01	04950 DIABETIC CARE CENTER		0	0	0	90.01	
90.02	04951 ANTI-COAGULATION CLINIC		511,184	0	511,184	90.02	
90.03	04952 PALLIATIVE CARE		0	0	0	90.03	
90.04	04953 SPINE CENTER		543,005	0	543,005	90.04	
91.00	09100 EMERGENCY		21,949,198	0	21,949,198	91.00	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		8,522,177	0	8,522,177	92.00	
200.00	Subtotal (see instructions)		235,118,612	0	235,118,612	200.00	
201.00	Less Observation Beds		8,522,177	0	8,522,177	201.00	
202.00	Total (see instructions)		226,596,435	0	226,596,435	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0128	Period: From 01/01/2022 To 12/31/2022	Worksheet C Part I Date/Time Prepared: 5/25/2023 11:46 am
		Title XVIII	Hospital	PPS

Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
	Inpatient	Outpatient	Total (col. 6 + col. 7)			
	6.00	7.00	8.00			
	9.00	10.00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	122,822,927		122,822,927	30.00
31.00	03100	INTENSIVE CARE UNIT	15,869,571		15,869,571	31.00
43.00	04300	NURSERY	3,768,840		3,768,840	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	60,487,339	75,340,882	135,828,221	50.00
51.00	05100	RECOVERY ROOM	10,683,857	25,457,908	36,141,765	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	18,998,039	0	18,998,039	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,008,744	33,581,191	41,589,935	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	8,793,060	14,773,906	23,566,966	55.00
57.00	05700	CT SCAN	20,950,488	62,147,998	83,098,486	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	3,533,406	12,811,228	16,344,634	58.00
59.00	05900	CARDIAC CATHETERIZATION	44,043,145	75,663,755	119,706,900	59.00
60.00	06000	LABORATORY	33,397,409	27,347,633	60,745,042	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	18,451,581	2,661,672	21,113,253	65.00
66.00	06600	PHYSICAL THERAPY	2,841,162	8,368,941	11,210,103	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,382,536	1,148,917	3,531,453	67.00
68.00	06800	SPEECH PATHOLOGY	612,212	152,079	764,291	68.00
69.00	06900	ELECTROCARDIOLOGY	6,803,677	18,637,223	25,440,900	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	431,582	6,455,379	6,886,961	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	18,006,943	18,208,649	36,215,592	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	17,043,170	16,233,257	33,276,427	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	43,317,584	17,158,713	60,476,297	73.00
74.00	07400	RENAL DIALYSIS	2,332,228	0	2,332,228	74.00
76.00	03950	ENDOSCOPY	2,441,632	7,938,477	10,380,109	76.00
76.06	03330	IMAGING CENTER	101,104	18,612,549	18,713,653	76.06
76.97	07697	CARDIAC REHABILITATION	2,045	2,440,430	2,442,475	76.97
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	90.00
90.01	04950	DIABETIC CARE CENTER	0	0	0	90.01
90.02	04951	ANTI-COAGULATION CLINIC	5,684	1,802,193	1,807,877	90.02
90.03	04952	PALLIATIVE CARE	0	0	0	90.03
90.04	04953	SPINE CENTER	0	479,680	479,680	90.04
91.00	09100	EMERGENCY	38,601,910	136,623,621	175,225,531	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,686,363	8,044,952	10,731,315	92.00
200.00		Subtotal (see instructions)	507,418,238	592,091,233	1,099,509,471	200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)	507,418,238	592,091,233	1,099,509,471	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0128	Period: From 01/01/2022 To 12/31/2022	Worksheet C Part I Date/Time Prepared: 5/25/2023 11:46 am
		Title XVIII	Hospital	PPS

Cost Center Description		PPS Inpatient Ratio		
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
43.00	04300 NURSERY			43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.124868		50.00
51.00	05100 RECOVERY ROOM	0.179979		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.427514		52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.117581		54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.108855		55.00
57.00	05700 CT SCAN	0.036813		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.084077		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.048520		59.00
60.00	06000 LABORATORY	0.186226		60.00
64.00	06400 INTRAVENOUS THERAPY	0.000000		64.00
65.00	06500 RESPIRATORY THERAPY	0.215403		65.00
66.00	06600 PHYSICAL THERAPY	0.474897		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.390655		67.00
68.00	06800 SPEECH PATHOLOGY	0.390872		68.00
69.00	06900 ELECTROCARDIOLOGY	0.108932		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.230048		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.628081		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.346262		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.259527		73.00
74.00	07400 RENAL DIALYSIS	0.298928		74.00
76.00	03950 ENDOSCOPY	0.169482		76.00
76.06	03330 IMAGING CENTER	0.149599		76.06
76.97	07697 CARDIAC REHABILITATION	0.268709		76.97
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0.000000		90.00
90.01	04950 DIABETIC CARE CENTER	0.000000		90.01
90.02	04951 ANTI-COAGULATION CLINIC	0.282754		90.02
90.03	04952 PALLIATIVE CARE	0.000000		90.03
90.04	04953 SPINE CENTER	1.132015		90.04
91.00	09100 EMERGENCY	0.125263		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.794141		92.00
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: 15-0128

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

Worksheet C
Part I
Date/Time Prepared:
5/25/2023 11:46 am

		Title XIX		Hospital		PPS	
Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
				Total Costs	RCE Disallowance	Total Costs	
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	61,767,545		61,767,545	0	61,767,545	30.00
31.00	03100 INTENSIVE CARE UNIT	9,432,446		9,432,446	0	9,432,446	31.00
43.00	04300 NURSERY	1,674,718		1,674,718	0	1,674,718	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	17,476,582		17,476,582	0	17,476,582	50.00
51.00	05100 RECOVERY ROOM	6,504,753		6,504,753	0	6,504,753	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	8,121,924		8,121,924	0	8,121,924	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	4,890,176		4,890,176	0	4,890,176	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	2,565,386		2,565,386	0	2,565,386	55.00
57.00	05700 CT SCAN	3,059,134		3,059,134	0	3,059,134	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	1,374,202		1,374,202	0	1,374,202	58.00
59.00	05900 CARDIAC CATHETERIZATION	5,865,896		5,865,896	0	5,865,896	59.00
60.00	06000 LABORATORY	11,312,309		11,312,309	0	11,312,309	60.00
64.00	06400 INTRAVENOUS THERAPY	0		0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	4,547,861	0	4,547,861	0	4,547,861	65.00
66.00	06600 PHYSICAL THERAPY	5,401,723	0	5,401,723	0	5,401,723	66.00
67.00	06700 OCCUPATIONAL THERAPY	1,379,579	0	1,379,579	0	1,379,579	67.00
68.00	06800 SPEECH PATHOLOGY	298,740	0	298,740	0	298,740	68.00
69.00	06900 ELECTROCARDIOLOGY	2,771,324		2,771,324	0	2,771,324	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	1,584,334		1,584,334	0	1,584,334	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	22,746,335		22,746,335	0	22,746,335	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	11,522,352		11,522,352	0	11,522,352	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	15,695,244		15,695,244	0	15,695,244	73.00
74.00	07400 RENAL DIALYSIS	697,168		697,168	0	697,168	74.00
76.00	03950 ENDOSCOPY	1,759,245		1,759,245	0	1,759,245	76.00
76.06	03330 IMAGING CENTER	2,799,536		2,799,536	0	2,799,536	76.06
76.97	07697 CARDIAC REHABILITATION	656,315		656,315	0	656,315	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0		0	0	0	90.00
90.01	04950 DIABETIC CARE CENTER	0		0	0	0	90.01
90.02	04951 ANTI-COAGULATION CLINIC	511,184		511,184	0	511,184	90.02
90.03	04952 PALLIATIVE CARE	0		0	0	0	90.03
90.04	04953 SPINE CENTER	570,162		570,162	0	570,162	90.04
91.00	09100 EMERGENCY	22,176,642		22,176,642	0	22,176,642	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	8,522,177		8,522,177	0	8,522,177	92.00
200.00	Subtotal (see instructions)	237,684,992	0	237,684,992	0	237,684,992	200.00
201.00	Less Observation Beds	8,522,177		8,522,177	0	8,522,177	201.00
202.00	Total (see instructions)	229,162,815	0	229,162,815	0	229,162,815	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0128	Period: From 01/01/2022 To 12/31/2022	Worksheet C Part I Date/Time Prepared: 5/25/2023 11:46 am
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		Title XIX			Hospital	PPS	
Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
		Inpatient	Outpatient	Total (col. 6 + col. 7)			
		6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	122,822,927		122,822,927		30.00
31.00	03100	INTENSIVE CARE UNIT	15,869,571		15,869,571		31.00
43.00	04300	NURSERY	3,768,840		3,768,840		43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	60,487,339	75,340,882	135,828,221	0.128667	50.00
51.00	05100	RECOVERY ROOM	10,683,857	25,457,908	36,141,765	0.179979	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	18,998,039	0	18,998,039	0.427514	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,008,744	33,581,191	41,589,935	0.117581	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	8,793,060	14,773,906	23,566,966	0.108855	55.00
57.00	05700	CT SCAN	20,950,488	62,147,998	83,098,486	0.036813	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	3,533,406	12,811,228	16,344,634	0.084077	58.00
59.00	05900	CARDIAC CATHETERIZATION	44,043,145	75,663,755	119,706,900	0.049002	59.00
60.00	06000	LABORATORY	33,397,409	27,347,633	60,745,042	0.186226	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	18,451,581	2,661,672	21,113,253	0.215403	65.00
66.00	06600	PHYSICAL THERAPY	2,841,162	8,368,941	11,210,103	0.481862	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,382,536	1,148,917	3,531,453	0.390655	67.00
68.00	06800	SPEECH PATHOLOGY	612,212	152,079	764,291	0.390872	68.00
69.00	06900	ELECTROCARDIOLOGY	6,803,677	18,637,223	25,440,900	0.108932	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	431,582	6,455,379	6,886,961	0.230048	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	18,006,943	18,208,649	36,215,592	0.628081	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	17,043,170	16,233,257	33,276,427	0.346262	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	43,317,584	17,158,713	60,476,297	0.259527	73.00
74.00	07400	RENAL DIALYSIS	2,332,228	0	2,332,228	0.298928	74.00
76.00	03950	ENDOSCOPY	2,441,632	7,938,477	10,380,109	0.169482	76.00
76.06	03330	IMAGING CENTER	101,104	18,612,549	18,713,653	0.149599	76.06
76.97	07697	CARDIAC REHABILITATION	2,045	2,440,430	2,442,475	0.268709	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0.000000	90.00
90.01	04950	DIABETIC CARE CENTER	0	0	0	0.000000	90.01
90.02	04951	ANTI-COAGULATION CLINIC	5,684	1,802,193	1,807,877	0.282754	90.02
90.03	04952	PALLIATIVE CARE	0	0	0	0.000000	90.03
90.04	04953	SPINE CENTER	0	479,680	479,680	1.188630	90.04
91.00	09100	EMERGENCY	38,601,910	136,623,621	175,225,531	0.126561	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,686,363	8,044,952	10,731,315	0.794141	92.00
200.00		Subtotal (see instructions)	507,418,238	592,091,233	1,099,509,471		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	507,418,238	592,091,233	1,099,509,471		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0128	Period: From 01/01/2022 To 12/31/2022	Worksheet C Part I Date/Time Prepared: 5/25/2023 11:46 am
		Title XIX	Hospital	PPS

Cost Center Description		PPS Inpatient Ratio		
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
43.00	04300 NURSERY			43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.128667		50.00
51.00	05100 RECOVERY ROOM	0.179979		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.427514		52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.117581		54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.108855		55.00
57.00	05700 CT SCAN	0.036813		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.084077		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.049002		59.00
60.00	06000 LABORATORY	0.186226		60.00
64.00	06400 INTRAVENOUS THERAPY	0.000000		64.00
65.00	06500 RESPIRATORY THERAPY	0.215403		65.00
66.00	06600 PHYSICAL THERAPY	0.481862		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.390655		67.00
68.00	06800 SPEECH PATHOLOGY	0.390872		68.00
69.00	06900 ELECTROCARDIOLOGY	0.108932		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.230048		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.628081		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.346262		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.259527		73.00
74.00	07400 RENAL DIALYSIS	0.298928		74.00
76.00	03950 ENDOSCOPY	0.169482		76.00
76.06	03330 IMAGING CENTER	0.149599		76.06
76.97	07697 CARDIAC REHABILITATION	0.268709		76.97
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0.000000		90.00
90.01	04950 DIABETIC CARE CENTER	0.000000		90.01
90.02	04951 ANTI-COAGULATION CLINIC	0.282754		90.02
90.03	04952 PALLIATIVE CARE	0.000000		90.03
90.04	04953 SPINE CENTER	1.188630		90.04
91.00	09100 EMERGENCY	0.126561		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.794141		92.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

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

Provider CCN: 15-0128

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

Worksheet C Part II Date/Time Prepared: 5/25/2023 11:46 am

Cost Center Description		Title XIX			Hospital	PPS		
		Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	17,476,582	4,940,073	12,536,509	0	0	50.00
51.00	05100	RECOVERY ROOM	6,504,753	312,112	6,192,641	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	8,121,924	469,924	7,652,000	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,890,176	633,544	4,256,632	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	2,565,386	370,670	2,194,716	0	0	55.00
57.00	05700	CT SCAN	3,059,134	72,185	2,986,949	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,374,202	185,382	1,188,820	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	5,865,896	956,406	4,909,490	0	0	59.00
60.00	06000	LABORATORY	11,312,309	140,123	11,172,186	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	4,547,861	97,694	4,450,167	0	0	65.00
66.00	06600	PHYSICAL THERAPY	5,401,723	798,337	4,603,386	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,379,579	39,850	1,339,729	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	298,740	8,633	290,107	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	2,771,324	307,239	2,464,085	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,584,334	228,921	1,355,413	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	22,746,335	2,131,368	20,614,967	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	11,522,352	25,763	11,496,589	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	15,695,244	718,594	14,976,650	0	0	73.00
74.00	07400	RENAL DIALYSIS	697,168	26,903	670,265	0	0	74.00
76.00	03950	ENDOSCOPY	1,759,245	237,863	1,521,382	0	0	76.00
76.06	03330	IMAGING CENTER	2,799,536	543,249	2,256,287	0	0	76.06
76.97	07697	CARDIAC REHABILITATION	656,315	29,981	626,334	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	04950	DIABETIC CARE CENTER	0	0	0	0	0	90.01
90.02	04951	ANTI-COAGULATION CLINIC	511,184	2,103	509,081	0	0	90.02
90.03	04952	PALLIATIVE CARE	0	0	0	0	0	90.03
90.04	04953	SPINE CENTER	570,162	97,604	472,558	0	0	90.04
91.00	09100	EMERGENCY	22,176,642	1,056,727	21,119,915	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	8,522,177	368,891	8,153,286	0	0	92.00
200.00		Subtotal (sum of lines 50 thru 199)	164,810,283	14,800,139	150,010,144	0	0	200.00
201.00		Less Observation Beds	8,522,177	368,891	8,153,286	0	0	201.00
202.00		Total (line 200 minus line 201)	156,288,106	14,431,248	141,856,858	0	0	202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY		Provider CCN: 15-0128	Period: From 01/01/2022 To 12/31/2022	Worksheet C Part II Date/Time Prepared: 5/25/2023 11:46 am
		Title XIX		Hospital
				PPS

Cost Center Description		Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)	
		6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	17,476,582	135,828,221	0.128667	50.00
51.00	05100 RECOVERY ROOM	6,504,753	36,141,765	0.179979	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	8,121,924	18,998,039	0.427514	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	4,890,176	41,589,935	0.117581	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	2,565,386	23,566,966	0.108855	55.00
57.00	05700 CT SCAN	3,059,134	83,098,486	0.036813	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	1,374,202	16,344,634	0.084077	58.00
59.00	05900 CARDIAC CATHETERIZATION	5,865,896	119,706,900	0.049002	59.00
60.00	06000 LABORATORY	11,312,309	60,745,042	0.186226	60.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0.000000	64.00
65.00	06500 RESPIRATORY THERAPY	4,547,861	21,113,253	0.215403	65.00
66.00	06600 PHYSICAL THERAPY	5,401,723	11,210,103	0.481862	66.00
67.00	06700 OCCUPATIONAL THERAPY	1,379,579	3,531,453	0.390655	67.00
68.00	06800 SPEECH PATHOLOGY	298,740	764,291	0.390872	68.00
69.00	06900 ELECTROCARDIOLOGY	2,771,324	25,440,900	0.108932	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	1,584,334	6,886,961	0.230048	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	22,746,335	36,215,592	0.628081	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	11,522,352	33,276,427	0.346262	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	15,695,244	60,476,297	0.259527	73.00
74.00	07400 RENAL DIALYSIS	697,168	2,332,228	0.298928	74.00
76.00	03950 ENDOSCOPY	1,759,245	10,380,109	0.169482	76.00
76.06	03330 IMAGING CENTER	2,799,536	18,713,653	0.149599	76.06
76.97	07697 CARDIAC REHABILITATION	656,315	2,442,475	0.268709	76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0	0	0.000000	90.00
90.01	04950 DIABETIC CARE CENTER	0	0	0.000000	90.01
90.02	04951 ANTI-COAGULATION CLINIC	511,184	1,807,877	0.282754	90.02
90.03	04952 PALLIATIVE CARE	0	0	0.000000	90.03
90.04	04953 SPIRE CENTER	570,162	479,680	1.188630	90.04
91.00	09100 EMERGENCY	22,176,642	175,225,531	0.126561	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	8,522,177	10,731,315	0.794141	92.00
200.00	Subtotal (sum of lines 50 thru 199)	164,810,283	957,048,133		200.00
201.00	Less Observation Beds	8,522,177	0		201.00
202.00	Total (line 200 minus line 201)	156,288,106	957,048,133		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS				Provider CCN: 15-0128	Period: From 01/01/2022 To 12/31/2022	Worksheet D Part I Date/Time Prepared: 5/25/2023 11:46 am		
Title XVIII				Hospital		PPS		
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)		
		1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS	2,604,306	0	2,604,306	40,813	63.81	30.00	
31.00	INTENSIVE CARE UNIT	854,163		854,163	3,075	277.78	31.00	
43.00	NURSERY	95,076		95,076	2,245	42.35	43.00	
200.00	Total (lines 30 through 199)	3,553,545		3,553,545	46,133		200.00	
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)					
		6.00	7.00					
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS	9,075	579,076					30.00
31.00	INTENSIVE CARE UNIT	940	261,113					31.00
43.00	NURSERY	0	0					43.00
200.00	Total (lines 30 through 199)	10,015	840,189					200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 15-0128	Period: From 01/01/2022 To 12/31/2022	Worksheet D Part II Date/Time Prepared: 5/25/2023 11:46 am
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Cost Center Description		Title XVIII			Hospital	PPS		
		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	4,940,073	135,828,221	0.036370	18,092,203	658,013	50.00
51.00	05100	RECOVERY ROOM	312,112	36,141,765	0.008636	2,591,438	22,380	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	469,924	18,998,039	0.024735	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	633,544	41,589,935	0.015233	2,320,433	35,347	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	370,670	23,566,966	0.015728	3,272,600	51,471	55.00
57.00	05700	CT SCAN	72,185	83,098,486	0.000869	6,547,731	5,690	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	185,382	16,344,634	0.011342	1,092,008	12,386	58.00
59.00	05900	CARDIAC CATHETERIZATION	956,406	119,706,900	0.007990	12,491,247	99,805	59.00
60.00	06000	LABORATORY	140,123	60,745,042	0.002307	9,920,894	22,888	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	97,694	21,113,253	0.004627	5,165,200	23,899	65.00
66.00	06600	PHYSICAL THERAPY	798,337	11,210,103	0.071216	991,989	70,645	66.00
67.00	06700	OCCUPATIONAL THERAPY	39,850	3,531,453	0.011284	860,176	9,706	67.00
68.00	06800	SPEECH PATHOLOGY	8,633	764,291	0.011295	212,140	2,396	68.00
69.00	06900	ELECTROCARDIOLOGY	307,239	25,440,900	0.012077	2,255,991	27,246	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	228,921	6,886,961	0.033240	139,404	4,634	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,131,368	36,215,592	0.058852	4,365,460	256,916	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	25,763	33,276,427	0.000774	5,449,137	4,218	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	718,594	60,476,297	0.011882	11,179,796	132,838	73.00
74.00	07400	RENAL DIALYSIS	26,903	2,332,228	0.011535	825,388	9,521	74.00
76.00	03950	ENDOSCOPY	237,863	10,380,109	0.022915	42,165	966	76.00
76.06	03330	IMAGING CENTER	543,249	18,713,653	0.029030	7,978	232	76.06
76.97	07697	CARDIAC REHABILITATION	29,981	2,442,475	0.012275	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
90.01	04950	DIABETIC CARE CENTER	0	0	0.000000	0	0	90.01
90.02	04951	ANTI-COAGULATION CLINIC	2,103	1,807,877	0.001163	0	0	90.02
90.03	04952	PALLIATIVE CARE	0	0	0.000000	0	0	90.03
90.04	04953	SPINE CENTER	97,604	479,680	0.203477	0	0	90.04
91.00	09100	EMERGENCY	1,056,727	175,225,531	0.006031	12,352,858	74,500	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	368,891	10,731,315	0.034375	964,408	33,152	92.00
200.00		Total (lines 50 through 199)	14,800,139	957,048,133		101,140,644	1,558,849	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0128	Period: From 01/01/2022 To 12/31/2022	Worksheet D Part III Date/Time Prepared: 5/25/2023 11:46 am
Title XVIII		Hospital	PPS

Cost Center Description			Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost		
			1A	1.00	2A	2.00	3.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00	
43.00	04300	NURSERY	0	0	0	0	0	43.00	
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00	
Cost Center Description			Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 + col. 6)	Inpatient Program Days		
			4.00	5.00	6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	0	0	40,813	0.00	9,075	30.00	
31.00	03100	INTENSIVE CARE UNIT		0	3,075	0.00	940	31.00	
43.00	04300	NURSERY		0	2,245	0.00	0	43.00	
200.00		Total (lines 30 through 199)		0	46,133		10,015	200.00	
Cost Center Description			Inpatient Program Pass-Through Cost (col. 7 x col. 8)						
			9.00						
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	0						30.00
31.00	03100	INTENSIVE CARE UNIT	0						31.00
43.00	04300	NURSERY	0						43.00
200.00		Total (lines 30 through 199)	0						200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0128	Period: From 01/01/2022 To 12/31/2022	Worksheet D Part IV Date/Time Prepared: 5/25/2023 11:46 am
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Cost Center Description	Title XVIII						Hospital	
	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	PPS		
	1.00	2A	2.00	3A	3.00			
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
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
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	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
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	ENDOSCOPY	0	0	0	0	0	76.00
76.06	03330	IMAGING CENTER	0	0	0	0	0	76.06
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	04950	DIABETIC CARE CENTER	0	0	0	0	0	90.01
90.02	04951	ANTI-COAGULATION CLINIC	0	0	0	0	0	90.02
90.03	04952	PALLIATIVE CARE	0	0	0	0	0	90.03
90.04	04953	SPINE CENTER	0	0	0	0	0	90.04
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	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: 15-0128	Period: From 01/01/2022 To 12/31/2022	Worksheet D Part IV Date/Time Prepared: 5/25/2023 11:46 am
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Cost Center Description	Title XVIII				Hospital	PPS		
	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	135,828,221	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	36,141,765	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	18,998,039	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	41,589,935	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	23,566,966	0.000000	55.00
57.00	05700	CT SCAN	0	0	0	83,098,486	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	16,344,634	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	119,706,900	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	60,745,042	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	21,113,253	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	11,210,103	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	3,531,453	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	764,291	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	25,440,900	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	6,886,961	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	36,215,592	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	33,276,427	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	60,476,297	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	2,332,228	0.000000	74.00
76.00	03950	ENDOSCOPY	0	0	0	10,380,109	0.000000	76.00
76.06	03330	IMAGING CENTER	0	0	0	18,713,653	0.000000	76.06
76.97	07697	CARDIAC REHABILITATION	0	0	0	2,442,475	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00
90.01	04950	DIABETIC CARE CENTER	0	0	0	0	0.000000	90.01
90.02	04951	ANTI-COAGULATION CLINIC	0	0	0	1,807,877	0.000000	90.02
90.03	04952	PALLIATIVE CARE	0	0	0	0	0.000000	90.03
90.04	04953	SPINE CENTER	0	0	0	479,680	0.000000	90.04
91.00	09100	EMERGENCY	0	0	0	175,225,531	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	10,731,315	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	957,048,133		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0128	Period: From 01/01/2022 To 12/31/2022	Worksheet D Part IV Date/Time Prepared: 5/25/2023 11:46 am
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Cost Center Description		Title XVIII			Hospital		PPS
		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	18,092,203	0	12,011,218	0	50.00
51.00	05100 RECOVERY ROOM	0.000000	2,591,438	0	4,981,103	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	2,320,433	0	6,293,336	0	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000	3,272,600	0	4,935,683	0	55.00
57.00	05700 CT SCAN	0.000000	6,547,731	0	9,806,312	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	1,092,008	0	2,531,463	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	12,491,247	0	22,450,449	0	59.00
60.00	06000 LABORATORY	0.000000	9,920,894	0	3,910,931	0	60.00
64.00	06400 INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.000000	5,165,200	0	318,455	0	65.00
66.00	06600 PHYSICAL THERAPY	0.000000	991,989	0	27,587	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	860,176	0	10,046	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	212,140	0	1,632	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	2,255,991	0	4,599,921	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	139,404	0	1,153,776	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	4,365,460	0	4,010,903	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	5,449,137	0	4,325,825	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	11,179,796	0	3,949,469	0	73.00
74.00	07400 RENAL DIALYSIS	0.000000	825,388	0	0	0	74.00
76.00	03950 ENDOSCOPY	0.000000	42,165	0	1,561,862	0	76.00
76.06	03330 IMAGING CENTER	0.000000	7,978	0	3,210,337	0	76.06
76.97	07697 CARDIAC REHABILITATION	0.000000	0	0	671,490	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0.000000	0	0	0	0	90.00
90.01	04950 DIABETIC CARE CENTER	0.000000	0	0	0	0	90.01
90.02	04951 ANTI-COAGULATION CLINIC	0.000000	0	0	625,860	0	90.02
90.03	04952 PALLIATIVE CARE	0.000000	0	0	0	0	90.03
90.04	04953 SPINE CENTER	0.000000	0	0	0	0	90.04
91.00	09100 EMERGENCY	0.000000	12,352,858	0	14,804,459	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	964,408	0	492,046	0	92.00
200.00	Total (lines 50 through 199)		101,140,644	0	106,684,163	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 15-0128	Period: From 01/01/2022 To 12/31/2022	Worksheet D Part V Date/Time Prepared: 5/25/2023 11:46 am
		Title XVIII	Hospital	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs		
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
	1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0.124868	12,011,218	11	0	1,499,817	50.00
51.00	05100 RECOVERY ROOM	0.179979	4,981,103	0	0	896,494	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.427514	0	0	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.117581	6,293,336	0	0	739,977	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.108855	4,935,683	0	0	537,274	55.00
57.00	05700 CT SCAN	0.036813	9,806,312	0	0	361,000	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.084077	2,531,463	0	0	212,838	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.048520	22,450,449	0	0	1,089,296	59.00
60.00	06000 LABORATORY	0.186226	3,910,931	180	0	728,317	60.00
64.00	06400 INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.215403	318,455	0	0	68,596	65.00
66.00	06600 PHYSICAL THERAPY	0.474897	27,587	0	0	13,101	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.390655	10,046	0	0	3,925	67.00
68.00	06800 SPEECH PATHOLOGY	0.390872	1,632	0	0	638	68.00
69.00	06900 ELECTROCARDIOLOGY	0.108932	4,599,921	0	0	501,079	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.230048	1,153,776	0	0	265,424	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.628081	4,010,903	0	0	2,519,172	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.346262	4,325,825	0	0	1,497,869	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.259527	3,949,469	0	167,496	1,024,994	73.00
74.00	07400 RENAL DIALYSIS	0.298928	0	0	0	0	74.00
76.00	03950 ENDOSCOPY	0.169482	1,561,862	0	0	264,707	76.00
76.06	03330 IMAGING CENTER	0.149599	3,210,337	0	0	480,263	76.06
76.97	07697 CARDIAC REHABILITATION	0.268709	671,490	0	0	180,435	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0.000000	0	0	0	0	90.00
90.01	04950 DIABETIC CARE CENTER	0.000000	0	0	0	0	90.01
90.02	04951 ANTI-COAGULATION CLINIC	0.282754	625,860	0	0	176,964	90.02
90.03	04952 PALLIATIVE CARE	0.000000	0	0	0	0	90.03
90.04	04953 SPINE CENTER	1.132015	0	0	0	0	90.04
91.00	09100 EMERGENCY	0.125263	14,804,459	0	0	1,854,451	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.794141	492,046	0	0	390,754	92.00
200.00	Subtotal (see instructions)		106,684,163	191	167,496	15,307,385	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00	Net Charges (line 200 - line 201)		106,684,163	191	167,496	15,307,385	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0128	Period: From 01/01/2022 To 12/31/2022	Worksheet D Part V Date/Time Prepared: 5/25/2023 11:46 am
	Title XVIII	Hospital	PPS

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	1	0	50.00
51.00	05100 RECOVERY ROOM	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	55.00
57.00	05700 CT SCAN	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000 LABORATORY	34	0	60.00
64.00	06400 INTRAVENOUS THERAPY	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	43,470	73.00
74.00	07400 RENAL DIALYSIS	0	0	74.00
76.00	03950 ENDOSCOPY	0	0	76.00
76.06	03330 IMAGING CENTER	0	0	76.06
76.97	07697 CARDIAC REHABILITATION	0	0	76.97
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0	0	90.00
90.01	04950 DIABETIC CARE CENTER	0	0	90.01
90.02	04951 ANTI-COAGULATION CLINIC	0	0	90.02
90.03	04952 PALLIATIVE CARE	0	0	90.03
90.04	04953 SPINE CENTER	0	0	90.04
91.00	09100 EMERGENCY	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
200.00	Subtotal (see instructions)	35	43,470	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00	Net Charges (line 200 - line 201)	35	43,470	202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 15-0128	Period: From 01/01/2022 To 12/31/2022	Worksheet D Part I Date/Time Prepared: 5/25/2023 11:46 am
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Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	4.00	5.00	
30.00	ADULTS & PEDIATRICS	2,604,306	0	2,604,306	40,813	63.81	30.00
31.00	INTENSIVE CARE UNIT	854,163		854,163	3,075	277.78	31.00
43.00	NURSERY	95,076		95,076	2,245	42.35	43.00
200.00	Total (lines 30 through 199)	3,553,545		3,553,545	46,133		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
INPATIENT ROUTINE SERVICE COST CENTERS		6.00	7.00				
30.00	ADULTS & PEDIATRICS	1,219	77,784				
31.00	INTENSIVE CARE UNIT	209	58,056				
43.00	NURSERY	1,376	58,274				
200.00	Total (lines 30 through 199)	2,804	194,114				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 15-0128	Period: From 01/01/2022 To 12/31/2022	Worksheet D Part II Date/Time Prepared: 5/25/2023 11:46 am
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Cost Center Description		Title XIX			Hospital	PPS		
		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	4,940,073	135,828,221	0.036370	1,079,235	39,252	50.00
51.00	05100	RECOVERY ROOM	312,112	36,141,765	0.008636	230,419	1,990	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	469,924	18,998,039	0.024735	257,029	6,358	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	633,544	41,589,935	0.015233	264,888	4,035	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	370,670	23,566,966	0.015728	398,374	6,266	55.00
57.00	05700	CT SCAN	72,185	83,098,486	0.000869	834,348	725	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	185,382	16,344,634	0.011342	139,552	1,583	58.00
59.00	05900	CARDIAC CATHETERIZATION	956,406	119,706,900	0.007990	703,174	5,618	59.00
60.00	06000	LABORATORY	140,123	60,745,042	0.002307	1,402,712	3,236	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	97,694	21,113,253	0.004627	679,807	3,145	65.00
66.00	06600	PHYSICAL THERAPY	798,337	11,210,103	0.071216	73,331	5,222	66.00
67.00	06700	OCCUPATIONAL THERAPY	39,850	3,531,453	0.011284	57,797	652	67.00
68.00	06800	SPEECH PATHOLOGY	8,633	764,291	0.011295	21,676	245	68.00
69.00	06900	ELECTROCARDIOLOGY	307,239	25,440,900	0.012077	194,388	2,348	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	228,921	6,886,961	0.033240	35,213	1,170	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,131,368	36,215,592	0.058852	642,939	37,838	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	25,763	33,276,427	0.000774	296,757	230	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	718,594	60,476,297	0.011882	1,800,782	21,397	73.00
74.00	07400	RENAL DIALYSIS	26,903	2,332,228	0.011535	136,038	1,569	74.00
76.00	03950	ENDOSCOPY	237,863	10,380,109	0.022915	86,013	1,971	76.00
76.06	03330	IMAGING CENTER	543,249	18,713,653	0.029030	0	0	76.06
76.97	07697	CARDIAC REHABILITATION	29,981	2,442,475	0.012275	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
90.01	04950	DIABETIC CARE CENTER	0	0	0.000000	0	0	90.01
90.02	04951	ANTI-COAGULATION CLINIC	2,103	1,807,877	0.001163	0	0	90.02
90.03	04952	PALLIATIVE CARE	0	0	0.000000	0	0	90.03
90.04	04953	SPINE CENTER	97,604	479,680	0.203477	0	0	90.04
91.00	09100	EMERGENCY	1,056,727	175,225,531	0.006031	1,513,330	9,127	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	368,891	10,731,315	0.034375	14,698	505	92.00
200.00		Total (lines 50 through 199)	14,800,139	957,048,133		10,862,500	154,482	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0128	Period: From 01/01/2022 To 12/31/2022	Worksheet D Part III Date/Time Prepared: 5/25/2023 11:46 am
Title XIX		Hospital	PPS

Cost Center Description			Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost		
			1A	1.00	2A	2.00	3.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00	
43.00	04300	NURSERY	0	0	0	0	0	43.00	
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00	
Cost Center Description			Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 + col. 6)	Inpatient Program Days		
			4.00	5.00	6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	0	0	40,813	0.00	1,219	30.00	
31.00	03100	INTENSIVE CARE UNIT		0	3,075	0.00	209	31.00	
43.00	04300	NURSERY		0	2,245	0.00	1,376	43.00	
200.00		Total (lines 30 through 199)		0	46,133		2,804	200.00	
Cost Center Description			Inpatient Program Pass-Through Cost (col. 7 x col. 8)						
			9.00						
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	0						30.00
31.00	03100	INTENSIVE CARE UNIT	0						31.00
43.00	04300	NURSERY	0						43.00
200.00		Total (lines 30 through 199)	0						200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0128

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

Worksheet D
Part IV
Date/Time Prepared:
5/25/2023 11:46 am

Cost Center Description			Title XIX				Hospital		PPS
			Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health		
			1.00	2A	2.00	3A	3.00		
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00	
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00	
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00	
57.00	05700	CT SCAN	0	0	0	0	0	57.00	
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00	
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00	
60.00	06000	LABORATORY	0	0	0	0	0	60.00	
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00	
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	
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	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	
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00	
76.00	03950	ENDOSCOPY	0	0	0	0	0	76.00	
76.06	03330	IMAGING CENTER	0	0	0	0	0	76.06	
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97	
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0	0	0	0	0	90.00	
90.01	04950	DIABETIC CARE CENTER	0	0	0	0	0	90.01	
90.02	04951	ANTI-COAGULATION CLINIC	0	0	0	0	0	90.02	
90.03	04952	PALLIATIVE CARE	0	0	0	0	0	90.03	
90.04	04953	SPINE CENTER	0	0	0	0	0	90.04	
91.00	09100	EMERGENCY	0	0	0	0	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	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: 15-0128	Period: From 01/01/2022 To 12/31/2022	Worksheet D Part IV Date/Time Prepared: 5/25/2023 11:46 am
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Cost Center Description	Title XIX			Hospital	PPS			
	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	135,828,221	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	36,141,765	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	18,998,039	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	41,589,935	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	23,566,966	0.000000	55.00
57.00	05700	CT SCAN	0	0	0	83,098,486	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	16,344,634	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	119,706,900	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	60,745,042	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	21,113,253	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	11,210,103	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	3,531,453	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	764,291	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	25,440,900	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	6,886,961	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	36,215,592	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	33,276,427	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	60,476,297	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	2,332,228	0.000000	74.00
76.00	03950	ENDOSCOPY	0	0	0	10,380,109	0.000000	76.00
76.06	03330	IMAGING CENTER	0	0	0	18,713,653	0.000000	76.06
76.97	07697	CARDIAC REHABILITATION	0	0	0	2,442,475	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00
90.01	04950	DIABETIC CARE CENTER	0	0	0	0	0.000000	90.01
90.02	04951	ANTI-COAGULATION CLINIC	0	0	0	1,807,877	0.000000	90.02
90.03	04952	PALLIATIVE CARE	0	0	0	0	0.000000	90.03
90.04	04953	SPINE CENTER	0	0	0	479,680	0.000000	90.04
91.00	09100	EMERGENCY	0	0	0	175,225,531	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	10,731,315	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	957,048,133		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0128	Period: From 01/01/2022 To 12/31/2022	Worksheet D Part IV Date/Time Prepared: 5/25/2023 11:46 am
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Cost Center Description		Title XIX			Hospital		PPS
		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)	
ANCILLARY SERVICE COST CENTERS		9.00	10.00	11.00	12.00	13.00	
50.00	05000 OPERATING ROOM	0.000000	1,079,235	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0.000000	230,419	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	257,029	0	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	264,888	0	0	0	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000	398,374	0	0	0	55.00
57.00	05700 CT SCAN	0.000000	834,348	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	139,552	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	703,174	0	0	0	59.00
60.00	06000 LABORATORY	0.000000	1,402,712	0	0	0	60.00
64.00	06400 INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.000000	679,807	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.000000	73,331	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	57,797	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	21,676	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	194,388	0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	35,213	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	642,939	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	296,757	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	1,800,782	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0.000000	136,038	0	0	0	74.00
76.00	03950 ENDOSCOPY	0.000000	86,013	0	0	0	76.00
76.06	03330 IMAGING CENTER	0.000000	0	0	0	0	76.06
76.97	07697 CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0.000000	0	0	0	0	90.00
90.01	04950 DIABETIC CARE CENTER	0.000000	0	0	0	0	90.01
90.02	04951 ANTI-COAGULATION CLINIC	0.000000	0	0	0	0	90.02
90.03	04952 PALLIATIVE CARE	0.000000	0	0	0	0	90.03
90.04	04953 SPINE CENTER	0.000000	0	0	0	0	90.04
91.00	09100 EMERGENCY	0.000000	1,513,330	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	14,698	0	0	0	92.00
200.00	Total (lines 50 through 199)		10,862,500	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 15-0128	Period: From 01/01/2022 To 12/31/2022	Worksheet D Part V Date/Time Prepared: 5/25/2023 11:46 am
		Title XIX	Hospital	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs		
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
	1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0.128667	0	1,063,349	0	0	50.00
51.00	05100 RECOVERY ROOM	0.179979	0	387,371	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.427514	0	0	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.117581	0	713,021	0	0	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.108855	0	206,207	0	0	55.00
57.00	05700 CT SCAN	0.036813	0	1,992,333	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.084077	0	281,087	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.049002	0	482,899	0	0	59.00
60.00	06000 LABORATORY	0.186226	0	921,645	0	0	60.00
64.00	06400 INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.215403	0	115,864	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.481862	0	78,303	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.390655	0	13,809	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.390872	0	3,087	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.108932	0	141,267	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.230048	0	65,258	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.628081	0	460,804	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.346262	0	217,114	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.259527	0	582,879	0	0	73.00
74.00	07400 RENAL DIALYSIS	0.298928	0	0	0	0	74.00
76.00	03950 ENDOSCOPY	0.169482	0	66,904	0	0	76.00
76.06	03330 IMAGING CENTER	0.149599	0	141,309	0	0	76.06
76.97	07697 CARDIAC REHABILITATION	0.268709	0	773	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0.000000	0	0	0	0	90.00
90.01	04950 DIABETIC CARE CENTER	0.000000	0	0	0	0	90.01
90.02	04951 ANTI-COAGULATION CLINIC	0.282754	0	21,913	0	0	90.02
90.03	04952 PALLIATIVE CARE	0.000000	0	0	0	0	90.03
90.04	04953 SPINE CENTER	1.188630	0	0	0	0	90.04
91.00	09100 EMERGENCY	0.126561	0	6,367,320	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.794141	0	15,888	0	0	92.00
200.00	Subtotal (see instructions)		0	14,340,404	0	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	0	201.00
202.00	Net Charges (line 200 - line 201)		0	14,340,404	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 15-0128	Period: From 01/01/2022 To 12/31/2022	Worksheet D Part V Date/Time Prepared: 5/25/2023 11:46 am
		Title XIX	Hospital	PPS

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	136,818	0	50.00
51.00	05100 RECOVERY ROOM	69,719	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	83,838	0	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	22,447	0	55.00
57.00	05700 CT SCAN	73,344	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	23,633	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	23,663	0	59.00
60.00	06000 LABORATORY	171,634	0	60.00
64.00	06400 INTRAVENOUS THERAPY	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	24,957	0	65.00
66.00	06600 PHYSICAL THERAPY	37,731	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	5,395	0	67.00
68.00	06800 SPEECH PATHOLOGY	1,207	0	68.00
69.00	06900 ELECTROCARDIOLOGY	15,388	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	15,012	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	289,422	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	75,178	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	151,273	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	74.00
76.00	03950 ENDOSCOPY	11,339	0	76.00
76.06	03330 IMAGING CENTER	21,140	0	76.06
76.97	07697 CARDIAC REHABILITATION	208	0	76.97
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0	0	90.00
90.01	04950 DIABETIC CARE CENTER	0	0	90.01
90.02	04951 ANTI-COAGULATION CLINIC	6,196	0	90.02
90.03	04952 PALLIATIVE CARE	0	0	90.03
90.04	04953 SPINE CENTER	0	0	90.04
91.00	09100 EMERGENCY	805,854	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	12,617	0	92.00
200.00	Subtotal (see instructions)	2,078,013	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00	Net Charges (line 200 - line 201)	2,078,013	0	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0128	Period: From 01/01/2022 To 12/31/2022	Worksheet D-1 Date/Time Prepared: 5/25/2023 11:46 am
Cost Center Description		Title XVIII	Hospital	PPS
		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		40,813	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		40,813	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)		35,032	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		9,075	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		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		60,165,256	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		60,165,256	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)		60,165,256	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,474.17	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		13,378,093	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)		13,378,093	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0128		Period: From 01/01/2022 To 12/31/2022		Worksheet D-1	
Title XVIII		Hospital		PPS		Date/Time Prepared: 5/25/2023 11:46 am	
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)		
42.00 NURSERY (title V & XIX only)	1.00	2.00	3.00	4.00	5.00	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	9,374,736	3,075	3,048.69	940	2,865,769		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)					18,519,996		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)					34,763,858		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)					840,189		50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					1,558,849		51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					2,399,038		52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthesiologist, and medical education costs (line 49 minus line 52)					32,364,820		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)						5,781	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						1,474.17	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)						8,522,177	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0128		Period: From 01/01/2022 To 12/31/2022		Worksheet D-1 Date/Time Prepared: 5/25/2023 11:46 am	
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)	PPS
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	2,604,306	60,165,256	0.043286	8,522,177	368,891	90.00
91.00	Nursing Program cost	0	60,165,256	0.000000	8,522,177	0	91.00
92.00	Allied health cost	0	60,165,256	0.000000	8,522,177	0	92.00
93.00	All other Medical Education	0	60,165,256	0.000000	8,522,177	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0128	Period: From 01/01/2022 To 12/31/2022	Worksheet D-1 Date/Time Prepared: 5/25/2023 11:46 am
		Title XIX	Hospital	PPS
Cost Center Description		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		40,813	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		40,813	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)		35,032	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		1,219	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)		2,245	15.00
16.00	Nursery days (title V or XIX only)		1,376	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		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		61,767,545	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		61,767,545	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)		61,767,545	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,513.43	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,844,871	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		1,844,871	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0128		Period: From 01/01/2022 To 12/31/2022		Worksheet D-1 Date/Time Prepared: 5/25/2023 11:46 am	
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)	PPS
42.00	NURSERY (title V & XIX only)	1,674,718	2,245	745.98	1,376	1,026,468	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	9,432,446	3,075	3,067.46	209	641,099	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)					2,177,319	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)					5,689,757	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)					194,114	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					154,482	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					348,596	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					5,341,161	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)					5,781	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,513.43	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					8,749,139	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0128		Period: From 01/01/2022 To 12/31/2022		Worksheet D-1 Date/Time Prepared: 5/25/2023 11:46 am	
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	2,604,306	61,767,545	0.042163	8,749,139	368,890	90.00
91.00	Nursing Program cost	0	61,767,545	0.000000	8,749,139	0	91.00
92.00	Allied health cost	0	61,767,545	0.000000	8,749,139	0	92.00
93.00	All other Medical Education	0	61,767,545	0.000000	8,749,139	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0128	Period: From 01/01/2022 To 12/31/2022	Worksheet D-3 Date/Time Prepared: 5/25/2023 11:46 am	
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		21,752,849	30.00
31.00	03100	INTENSIVE CARE UNIT		4,263,134	31.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.124868	18,092,203	50.00
51.00	05100	RECOVERY ROOM	0.179979	2,591,438	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.427514	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.117581	2,320,433	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.108855	3,272,600	55.00
57.00	05700	CT SCAN	0.036813	6,547,731	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.084077	1,092,008	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.048520	12,491,247	59.00
60.00	06000	LABORATORY	0.186226	9,920,894	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.215403	5,165,200	65.00
66.00	06600	PHYSICAL THERAPY	0.474897	991,989	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.390655	860,176	67.00
68.00	06800	SPEECH PATHOLOGY	0.390872	212,140	68.00
69.00	06900	ELECTROCARDIOLOGY	0.108932	2,255,991	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.230048	139,404	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.628081	4,365,460	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.346262	5,449,137	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.259527	11,179,796	73.00
74.00	07400	RENAL DIALYSIS	0.298928	825,388	74.00
76.00	03950	ENDOSCOPY	0.169482	42,165	76.00
76.06	03330	IMAGING CENTER	0.149599	7,978	76.06
76.97	07697	CARDIAC REHABILITATION	0.268709	0	76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.000000	0	90.00
90.01	04950	DIABETIC CARE CENTER	0.000000	0	90.01
90.02	04951	ANTI-COAGULATION CLINIC	0.282754	0	90.02
90.03	04952	PALLIATIVE CARE	0.000000	0	90.03
90.04	04953	SPINE CENTER	1.132015	0	90.04
91.00	09100	EMERGENCY	0.125263	12,352,858	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.794141	964,408	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		101,140,644	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)		101,140,644	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0128	Period: From 01/01/2022 To 12/31/2022	Worksheet D-3 Date/Time Prepared: 5/25/2023 11:46 am	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		4,272,322	30.00
31.00	03100	INTENSIVE CARE UNIT		789,940	31.00
43.00	04300	NURSERY		1,097,976	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.128667	1,079,235	138,862 50.00
51.00	05100	RECOVERY ROOM	0.179979	230,419	41,471 51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.427514	257,029	109,883 52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.117581	264,888	31,146 54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.108855	398,374	43,365 55.00
57.00	05700	CT SCAN	0.036813	834,348	30,715 57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.084077	139,552	11,733 58.00
59.00	05900	CARDIAC CATHETERIZATION	0.049002	703,174	34,457 59.00
60.00	06000	LABORATORY	0.186226	1,402,712	261,221 60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0 64.00
65.00	06500	RESPIRATORY THERAPY	0.215403	679,807	146,432 65.00
66.00	06600	PHYSICAL THERAPY	0.481862	73,331	35,335 66.00
67.00	06700	OCCUPATIONAL THERAPY	0.390655	57,797	22,579 67.00
68.00	06800	SPEECH PATHOLOGY	0.390872	21,676	8,473 68.00
69.00	06900	ELECTROCARDIOLOGY	0.108932	194,388	21,175 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.230048	35,213	8,101 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.628081	642,939	403,818 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.346262	296,757	102,756 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.259527	1,800,782	467,352 73.00
74.00	07400	RENAL DIALYSIS	0.298928	136,038	40,666 74.00
76.00	03950	ENDOSCOPY	0.169482	86,013	14,578 76.00
76.06	03330	IMAGING CENTER	0.149599	0	0 76.06
76.97	07697	CARDIAC REHABILITATION	0.268709	0	0 76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.000000	0	0 90.00
90.01	04950	DIABETIC CARE CENTER	0.000000	0	0 90.01
90.02	04951	ANTI-COAGULATION CLINIC	0.282754	0	0 90.02
90.03	04952	PALLIATIVE CARE	0.000000	0	0 90.03
90.04	04953	SPINE CENTER	1.188630	0	0 90.04
91.00	09100	EMERGENCY	0.126561	1,513,330	191,529 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.794141	14,698	11,672 92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		10,862,500	2,177,319 200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0 201.00
202.00		Net charges (line 200 minus line 201)		10,862,500	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0128	Period: From 01/01/2022 To 12/31/2022	Worksheet E Part A Date/Time Prepared: 5/25/2023 11:46 am
		Title XVIII	Hospital	PPS
		1.00		
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
1.00	DRG Amounts Other than Outlier Payments		0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		17,986,990	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		6,047,345	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)		0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)		0	1.04
2.00	Outlier payments for discharges. (see instructions)			2.00
2.01	Outlier reconciliation amount		0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)		0	2.02
2.03	Outlier payments for discharges occurring prior to October 1 (see instructions)		302,924	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)		137,077	2.04
3.00	Managed Care Simulated Payments		22,374,278	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		152.95	4.00
Indirect Medical Education Adjustment				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions)		0.00	5.00
5.01	FTE cap adjustment for qualifying hospitals under §131 of the CAA 2021 (see instructions)		0.00	5.01
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00	6.00
6.26	Rural track program FTE cap limitation adjustment after the cap-building window closed under §127 of the CAA 2021 (see instructions)		0.00	6.26
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00	7.01
7.02	Adjustment (increase or decrease) to the hospital's rural track program FTE limitation(s) for rural track programs with a rural track for Medicare GME affiliated programs in accordance with 413.75(b) and 87 FR 49075 (August 10, 2022) (see instructions)		0.00	7.02
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		6.25	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)		0.00	8.02
8.21	The amount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (see instructions)		0.00	8.21
9.00	Sum of lines 5 and 5.01, plus line 6, plus lines 6.26 through 6.49, minus lines 7 and 7.01, plus or minus line 7.02, plus/minus line 8, plus lines 8.01 through 8.27 (see instructions)		6.25	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		6.45	10.00
11.00	FTE count for residents in dental and podiatric programs.		1.35	11.00
12.00	Current year allowable FTE (see instructions)		7.60	12.00
13.00	Total allowable FTE count for the prior year.		8.63	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		8.39	14.00
15.00	Sum of lines 12 through 14 divided by 3.		8.21	15.00
16.00	Adjustment for residents in initial years of the program (see instructions)		0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00	17.00
18.00	Adjusted rolling average FTE count		8.21	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.053678	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.056101	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.053678	21.00
22.00	IME payment adjustment (see instructions)		694,424	22.00
22.01	IME payment adjustment - Managed Care (see instructions)		646,460	22.01
Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).		0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.20	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)		0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)		0	28.01
29.00	Total IME payment (sum of lines 22 and 28)		694,424	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		646,460	29.01
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		2.58	30.00
31.00	Percentage of Medicaid patient days (see instructions)		25.95	31.00
32.00	Sum of lines 30 and 31		28.53	32.00
33.00	Allowable disproportionate share percentage (see instructions)		12.75	33.00
34.00	Disproportionate share adjustment (see instructions)		766,094	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0128	Period: From 01/01/2022 To 12/31/2022	Worksheet E Part A Date/Time Prepared: 5/25/2023 11:46 am
		Title XVIII	Hospital	PPS
		Prior to 10/1	On/After 10/1	
		1.00	2.00	
Uncompensated Care Payment Adjustment				
35.00	Total uncompensated care amount (see instructions)	7,192,008,710	6,874,403,459	35.00
35.01	Factor 3 (see instructions)	0.000173193	0.000249838	35.01
35.02	Hospital UCP, including supplemental UCP (If line 34 is zero, enter zero on this line) (see instructions)	1,245,606	1,717,489	35.02
35.03	Pro rata share of the hospital UCP, including supplemental UCP (see instructions)	931,645	432,902	35.03
36.00	Total UCP adjustment (sum of columns 1 and 2 on line 35.03)	1,364,547		36.00
Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)				
40.00	Total Medicare discharges (see instructions)	0		40.00
41.00	Total ESRD Medicare discharges (see instructions)	0		41.00
41.01	Total ESRD Medicare covered and paid discharges (see instructions)	0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days (see instructions)	0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00
47.00	Subtotal (see instructions)	27,299,401		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)	0		48.00
		Amount		
		1.00		
49.00	Total payment for inpatient operating costs (see instructions)		27,945,861	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		1,910,300	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).		301,771	52.00
53.00	Nursing and Allied Health Managed Care payment		0	53.00
54.00	Special add-on payments for new technologies		278,893	54.00
54.01	Islet isolation add-on payment		0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0	55.00
55.01	Cellular therapy acquisition cost (see instructions)		0	55.01
56.00	Cost of physicians' services in a teaching hospital (see instructions)		0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		0	58.00
59.00	Total (sum of amounts on lines 49 through 58)		30,436,825	59.00
60.00	Primary payer payments		23,376	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		30,413,449	61.00
62.00	Deductibles billed to program beneficiaries		2,559,376	62.00
63.00	Coinurance billed to program beneficiaries		121,721	63.00
64.00	Allowable bad debts (see instructions)		83,775	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		54,454	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		14,397	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		27,786,806	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)		0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	70.00
70.50	Rural Community Hospital Demonstration Project (\$410A Demonstration) adjustment (see instructions)		0	70.50
70.75	N95 respirator payment adjustment amount (see instructions)		0	70.75
70.87	Demonstration payment adjustment amount before sequestration		0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)		0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		0	70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		0	70.91
70.92	Bundled Model 1 discount amount (see instructions)		0	70.92
70.93	HVBP payment adjustment amount (see instructions)		0	70.93
70.94	HRR adjustment amount (see instructions)		-45,496	70.94
70.95	Recovery of accelerated depreciation		0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0128	Period: From 01/01/2022 To 12/31/2022	Worksheet E Part A Date/Time Prepared: 5/25/2023 11:46 am	
		Title XVIII	Hospital	PPS	
		FFY (yyyy)	Amount		
		0	1.00		
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0		0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0		0	70.97
70.98	Low Volume Payment-3			0	70.98
70.99	HAC adjustment amount (see instructions)			0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)			27,741,310	71.00
71.01	Sequestration adjustment (see instructions)			349,540	71.01
71.02	Demonstration payment adjustment amount after sequestration			0	71.02
71.03	Sequestration adjustment-PARHM or CHART pass-throughs			0	71.03
72.00	Interim payments			26,857,459	72.00
72.01	Interim payments-PARHM or CHART				72.01
73.00	Tentative settlement (for contractor use only)			0	73.00
73.01	Tentative settlement-PARHM or CHART (for contractor use only)				73.01
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)			534,311	74.00
74.01	Balance due provider/program-PARHM or CHART (see instructions)				74.01
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			726,942	75.00
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)			0	90.00
91.00	Capital outlier from Wkst. L, Pt. 1, line 2			0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)			0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)			0	93.00
94.00	The rate used to calculate the time value of money (see instructions)			0.00	94.00
95.00	Time value of money for operating expenses (see instructions)			0	95.00
96.00	Time value of money for capital related expenses (see instructions)			0	96.00
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
HSP Bonus Payment Amount					
100.00	HSP bonus amount (see instructions)			0	100.00
HVBP Adjustment for HSP Bonus Payment					
101.00	HVBP adjustment factor (see instructions)		0.0000000000	0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)			0	102.00
HRR Adjustment for HSP Bonus Payment					
103.00	HRR adjustment factor (see instructions)		0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)			0	104.00
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 inpatient service costs (from Wkst. D-1, Pt. 11, line 49)				201.00
202.00	Medicare discharges (see instructions)				202.00
203.00	Case-mix adjustment factor (see instructions)				203.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)					
204.00	Medicare target amount				204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)				205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)				206.00
Adjustment to Medicare Part A Inpatient Reimbursement					
207.00	Program reimbursement under the §410A Demonstration (see instructions)				207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)				208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)				209.00
210.00	Reserved for future use				210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)				211.00
Comparison of PPS versus Cost Reimbursement					
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)				212.00
213.00	Low-volume adjustment (see instructions)				213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)				218.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0128	Period: From 01/01/2022 To 12/31/2022	Worksheet E Part B Date/Time Prepared: 5/25/2023 11:46 am
		Title XVIII	Hospital	PPS
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		43,505	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		15,307,385	2.00
3.00	OPPS payments		14,528,664	3.00
4.00	Outlier payment (see instructions)		87,465	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)		43,505	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		167,687	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)		167,687	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 charge basis 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)		167,687	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		124,182	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)		43,505	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)		14,616,129	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		2,533,825	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)		12,125,809	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		133,290	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)		12,259,099	30.00
31.00	Primary payer payments		6,239	31.00
32.00	Subtotal (line 30 minus line 31)		12,252,860	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)		155,949	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		101,367	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		127,596	36.00
37.00	Subtotal (see instructions)		12,354,227	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)		0	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)		61,904	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		12,354,227	40.00
40.01	Sequestration adjustment (see instructions)		155,664	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
40.03	Sequestration adjustment-PARHM or CHART pass-throughs		0	40.03
41.00	Interim payments		12,239,060	41.00
41.01	Interim payments-PARHM or CHART		0	41.01
42.00	Tentative settlement (for contractors use only)		0	42.00
42.01	Tentative settlement-PARHM or CHART (for contractor use only)		0	42.01
43.00	Balance due provider/program (see instructions)		-40,497	43.00
43.01	Balance due provider/program-PARHM (see instructions)		0	43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		825	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: 15-0128	Period: From 01/01/2022 To 12/31/2022	Worksheet E Part B Date/Time Prepared: 5/25/2023 11:46 am
		Title XVIII	Hospital
			PPS
			1.00
200.00	MEDI CARE PART B ANCI LLARY COSTS Part B Combined Billed Days		0 200.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-0128

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

Worksheet E-1
Part I
Date/Time Prepared:
5/25/2023 11:46 am

		Title XVIII		Hospital		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		26,857,459		12,239,060	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						3.00
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01	
3.02			0		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50	
3.51			0		0	3.51	
3.52			0		0	3.52	
3.53			0		0	3.53	
3.54			0		0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		26,857,459		12,239,060	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		534,311		0	6.01	
6.02	SETTLEMENT TO PROGRAM		0		40,497	6.02	
7.00	Total Medicare program liability (see instructions)		27,391,770		12,198,563	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: 15-0128	Period: From 01/01/2022 To 12/31/2022	Worksheet E-1 Part II Date/Time Prepared: 5/25/2023 11:46 am
		Title XVIII	Hospital	PPS
				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

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 15-0128	Period: From 01/01/2022 To 12/31/2022	Worksheet E-4 Date/Time Prepared: 5/25/2023 11:46 am	
		Title XVIII	Hospital	PPS	
				1.00	
COMPUTATION OF TOTAL DIRECT GME AMOUNT					
1.00	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.			0.00	1.00
1.01	FTE cap adjustment under §131 of the CAA 2021 (see instructions)			0.00	1.01
2.00	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)			0.00	2.00
2.26	Rural track program FTE cap limitation adjustment after the cap-building window closed under §127 of the CAA 2021 (see instructions)				2.26
3.00	Amount of reduction to Direct GME cap under section 422 of MMA			0.00	3.00
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)			0.00	3.01
3.02	Adjustment (increase or decrease) to the hospital's rural track FTE limitation(s) for rural track programs with a rural track Medicare GME affiliation agreement in accordance with 413.75(b) and 87 FR 49075 (August 10, 2022) (see instructions)				3.02
4.00	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))			6.25	4.00
4.01	ACA Section 5503 increase to the Direct GME FTE Cap (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.01
4.02	ACA Section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.02
4.21	The amount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (see instructions)				4.21
5.00	FTE adjusted cap (line 1 plus and 1.01, plus line 2, plus lines 2.26 through 2.49, minus lines 3 and 3.01, plus or minus line 3.02, plus or minus line 4, plus lines 4.01 through 4.27)			6.25	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			6.45	6.00
7.00	Enter the lesser of line 5 or line 6			6.25	7.00
		Primary Care	Other	Total	
		1.00	2.00	3.00	
8.00	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year.	5.78	0.67	6.45	8.00
9.00	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6. For cost reporting periods beginning on or after October 1, 2022, or if Worksheet S-2, Part I, line 68, is "Y", see instructions.	5.60	0.65	6.25	9.00
10.00	Weighted dental and podiatric resident FTE count for the current year		1.35		10.00
10.01	Unweighted dental and podiatric resident FTE count for the current year		1.35		10.01
11.00	Total weighted FTE count	5.60	2.00		11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	6.45	2.18		12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	5.47	2.00		13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	5.84	2.06		14.00
15.00	Adjustment for residents in initial years of new programs	0.00	0.00		15.00
15.01	Unweighted adjustment for residents in initial years of new programs	0.00	0.00		15.01
16.00	Adjustment for residents displaced by program or hospital closure	0.00	0.00		16.00
16.01	Unweighted adjustment for residents displaced by program or hospital closure	0.00	0.00		16.01
17.00	Adjusted rolling average FTE count	5.84	2.06		17.00
18.00	Per resident amount	106,221.21	106,221.21		18.00
18.01	Per resident amount under §131 of the CAA 2021				18.01
19.00	Approved amount for resident costs	620,332	218,816	839,148	19.00
				1.00	
20.00	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 Sec. 413.79(c)(4)			0.00	20.00
21.00	Direct GME FTE unweighted resident count over cap (see instructions)			0.20	21.00
22.00	Allowable additional direct GME FTE Resident Count (see instructions)			0.00	22.00
23.00	Enter the locality adjustment national average per resident amount (see instructions)			0.00	23.00
24.00	Multiply line 22 time line 23			0	24.00
25.00	Total direct GME amount (sum of lines 19 and 24)			839,148	25.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS	Provider CCN: 15-0128	Period: From 01/01/2022 To 12/31/2022	Worksheet E-4 Date/Time Prepared: 5/25/2023 11:46 am
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		Title XVIII		Hospital	PPS
		Inpatient Part A	Managed Care	Total	
		1.00	2.00	3.00	
COMPUTATION OF PROGRAM PATIENT LOAD					
26.00	Inpatient Days (see instructions) (Title XIX - see S-2 Part IX, line 3.02, column 2)	10,015	10,412		26.00
27.00	Total Inpatient Days (see instructions)	38,745	38,745		27.00
28.00	Ratio of inpatient days to total inpatient days	0.258485	0.268731		28.00
29.00	Program direct GME amount	216,907	225,505	442,412	29.00
29.01	Percent reduction for MA DGME		3.26		29.01
30.00	Reduction for direct GME payments for Medicare Advantage		7,351	7,351	30.00
31.00	Net Program direct GME amount			435,061	31.00
				1.00	
DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING PROGRAM AND PARAMEDICAL EDUCATION COSTS)					
32.00	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)			0	32.00
33.00	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)			2,332,228	33.00
34.00	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)			0.000000	34.00
35.00	Medicare outpatient ESRD charges (see instructions)			0	35.00
36.00	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)			0	36.00
APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY					
Part A Reasonable Cost					
37.00	Reasonable cost (see instructions)			34,763,858	37.00
38.00	Organ acquisition and HSCT acquisition costs (see instructions)			0	38.00
39.00	Cost of physicians' services in a teaching hospital (see instructions)			0	39.00
40.00	Primary payer payments (see instructions)			23,376	40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)			34,740,482	41.00
Part B Reasonable Cost					
42.00	Reasonable cost (see instructions)			15,350,890	42.00
43.00	Primary payer payments (see instructions)			6,239	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)			15,344,651	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)			50,085,133	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)			0.693629	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)			0.306371	47.00
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B					
48.00	Total program GME payment (line 31)			435,061	48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)			301,771	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)			133,290	50.00

OUTLIER RECONCILIATION AT TENTATIVE SETTLEMENT		Provider CCN: 15-0128	Period: From 01/01/2022 To 12/31/2022	Worksheet E-5 Date/Time Prepared: 5/25/2023 11:46 am
Title XVIII			PPS	
			1.00	
TO BE COMPLETED BY CONTRACTOR				
1.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	1.00
2.00	Capital outlier from Wkst. L, Pt. I, line 2		0	2.00
3.00	Operating outlier reconciliation adjustment amount (see instructions)		0	3.00
4.00	Capital outlier reconciliation adjustment amount (see instructions)		0	4.00
5.00	The rate used to calculate the time value of money (see instructions)		0.00	5.00
6.00	Time value of money for operating expenses (see instructions)		0	6.00
7.00	Time value of money for capital related expenses (see instructions)		0	7.00

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

Provider CCN: 15-0128

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

Worksheet G

Date/Time Prepared:
5/25/2023 11:46 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	5,849	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	222,684,755	0	0	0	4.00
5.00	Other receivable	-179,994,903	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	568,805	0	0	0	6.00
7.00	Inventory	4,780,016	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	11,828	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)	48,056,350	0	0	0	11.00
FIXED ASSETS						
12.00	Land	5,442,087	0	0	0	12.00
13.00	Land improvements	3,022,362	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	194,621,714	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	1,769,784	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	90,863,131	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	24,819	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	0	0	0	0	23.00
24.00	Accumulated depreciation	-164,865,138	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	115,657	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	130,994,416	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	640,829,100	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	640,829,100	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	819,879,866	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	542,183	0	0	0	37.00
38.00	Salaries, wages, and fees payable	0	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	2,953,868	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	3,496,051	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	4,227,924	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	4,227,924	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	7,723,975	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	812,155,891	0	0	0	52.00
53.00	Specific purpose fund	0	0	0	0	53.00
54.00	Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00	Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00	Governing body created - endowment fund balance	0	0	0	0	56.00
57.00	Plant fund balance - invested in plant	0	0	0	0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	812,155,891	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	819,879,866	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 15-0128

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

Worksheet G-1

Date/Time Prepared:
5/25/2023 11:46 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		762,151,748		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		50,004,142			2.00
3.00	Total (sum of line 1 and line 2)		812,155,890		0	3.00
4.00	ROUNDING	1		0		4.00
5.00		0		0		5.00
6.00		0		0		6.00
7.00		0		0		7.00
8.00		0		0		8.00
9.00		0		0		9.00
10.00	Total additions (sum of line 4-9)		1		0	10.00
11.00	Subtotal (line 3 plus line 10)		812,155,891		0	11.00
12.00	Deductions (debit adjustments) (specify)	0		0		12.00
13.00		0		0		13.00
14.00		0		0		14.00
15.00		0		0		15.00
16.00		0		0		16.00
17.00		0		0		17.00
18.00	Total deductions (sum of lines 12-17)		0		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		812,155,891		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	ROUNDING		0			4.00
5.00			0			5.00
6.00			0			6.00
7.00			0			7.00
8.00			0			8.00
9.00			0			9.00
10.00	Total additions (sum of line 4-9)	0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0		11.00
12.00	Deductions (debit adjustments) (specify)		0			12.00
13.00			0			13.00
14.00			0			14.00
15.00			0			15.00
16.00			0			16.00
17.00			0			17.00
18.00	Total deductions (sum of lines 12-17)	0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0		19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 15-0128

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

Worksheet G-2
Parts I & II
Date/Time Prepared:
5/25/2023 11:46 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	129,012,127		129,012,127	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	129,012,127		129,012,127	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	15,880,871		15,880,871	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)	15,880,871		15,880,871	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	144,892,998		144,892,998	17.00
18.00	Ancillary services	346,954,111	624,446,166	971,400,277	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	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	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	491,847,109	624,446,166	1,116,293,275	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		270,244,503		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		270,244,503		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 15-0128

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

Worksheet G-3

Date/Time Prepared:
5/25/2023 11:46 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	1,116,293,275	1.00
2.00	Less contractual allowances and discounts on patients' accounts	800,548,548	2.00
3.00	Net patient revenues (line 1 minus line 2)	315,744,727	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	270,244,503	4.00
5.00	Net income from service to patients (line 3 minus line 4)	45,500,224	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	125	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	11,723	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	1,246,265	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	747,893	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISC REVENUE	1,069,749	24.00
24.50	COVID-19 PHE Funding	1,380,886	24.50
25.00	Total other income (sum of lines 6-24)	4,456,641	25.00
26.00	Total (line 5 plus line 25)	49,956,865	26.00
27.00	TAXES	-47,277	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	-47,277	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	50,004,142	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 15-0128	Period: From 01/01/2022 To 12/31/2022	Worksheet L Parts I-III Date/Time Prepared: 5/25/2023 11:46 am
		Title XVII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		1,815,850	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		54,864	2.00
2.01	Model 4 BPCI Capital DRG outlier payments		0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)		107.12	3.00
4.00	Number of interns & residents (see instructions)		8.21	4.00
5.00	Indirect medical education percentage (see instructions)		2.18	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)		39,586	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		0.00	8.00
9.00	Sum of lines 7 and 8		0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)		0.00	10.00
11.00	Disproportionate share adjustment (see instructions)		0	11.00
12.00	Total prospective capital payments (see instructions)		1,910,300	12.00
		1.00		
PART II - PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instructions)		0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)		0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)		0	3.00
4.00	Capital cost payment factor (see instructions)		0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)		0	5.00
		1.00		
PART III - COMPUTATION OF EXCEPTION PAYMENTS				
1.00	Program inpatient capital costs (see instructions)		0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)		0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)		0	3.00
4.00	Applicable exception percentage (see instructions)		0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)		0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)		0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)		0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)		0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)		0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		0	14.00
15.00	Current year allowable operating and capital payment (see instructions)		0	15.00
16.00	Current year operating and capital costs (see instructions)		0	16.00
17.00	Current year exception offset amount (see instructions)		0	17.00