

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: 15-1318	Period: From 01/01/2022 To 12/31/2022	Worksheet S Parts I-III Date/Time Prepared: 5/31/2023 3:43 pm
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PART I - COST REPORT STATUS

Provider use only

1. Electronically prepared cost report
 2. Manually prepared cost report
 3. If this is an amended report enter the number of times the provider resubmitted this cost report
 4. Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no.

Date: 5/31/2023 Time: 3:43 pm

Contractor use only

5. 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. Initial Report for this Provider CCN
 9. Final Report for this Provider CCN

10. NPR Date:
 11. Contractor's Vendor Code: 4
 12. 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 DUKES MEMORIAL HOSPITAL (15-1318) 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			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			2
3	Signatory Title	VICE PRESIDENT, REVENUE MANAGEMEN		3
4	Date			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	484,736	-768,023	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	372,270	0	0	0 5.00
6.00	SWING BED - NF	0			0	0 6.00
200.00	TOTAL	0	857,006	-768,023	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: 15-1318	Period: From 01/01/2022 To 12/31/2022	Worksheet S-2 Part I Date/Time Prepared: 5/31/2023 3:43 pm
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1.00	2.00	3.00	4.00	1.00
Hospital and Hospital Health Care Complex Address:				
1.00	Street: 275 WEST 12TH STREET	PO Box:		1.00
2.00	City: PERU	State: IN	Zip Code: 46970	2.00
			County: MIAMI	

	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	DUKES MEMORIAL HOSPITAL	151318	99915	1	07/01/1966	N	O	P	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	DUKES MEMORIAL HOSPITAL SB	152318	99915		12/01/2003	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									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)					4		21.00	
						1.00	2.00	3.00	

Inpatient PPS Information									
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2) (Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.				N				22.00
22.01	Did this hospital receive interim UCPs, including supplemental UCPs, for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)				N	N			22.01
22.02	Is this a newly merged hospital that requires a final UCP to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.				N	N			22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)				N	N	N		22.03
22.04	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	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)								22.04
22.04	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.								
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

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	In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of- State Medicaid paid days	Out-of- State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days		
	1.00	2.00	3.00	4.00	5.00	6.00		
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.						0	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	25.00
					Urban/Rural	Date of Geogr		
					1.00	2.00		
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.				2		26.00	
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.				2		27.00	
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.				0		35.00	
					Beginning:	Ending:		
					1.00	2.00		
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.						36.00	
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.				0		37.00	
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)						37.01	
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.						38.00	
					Y/N	Y/N		
					1.00	2.00		
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)				N	N	39.00	
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)				N	N	40.00	
					V	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.				N			56.00
57.00	For cost reporting periods beginning prior to December 27, 2020, if line 56, column 1, is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.77(e)(1)(iv) and (v), regardless of which month(s) of the cost report the residents were on duty, if the response to line 56 is "Y" for yes, enter "Y" for yes in column 1, do not complete column 2, and complete Worksheet E-4.							57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.				N			58.00

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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	0.00	0.000000		66.00
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	

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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		Y 91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N		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		XIX			
		1.00		2.00			
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. 1, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y		Y			98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. 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. 1, 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. 1 through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y		Y			98.06
Rural Providers							
105.00	Does this hospital qualify as a CAH?	Y					105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N					106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N					107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N					108.00
		Physical 1.00		Occupational 2.00		Speech 3.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	Y		Y		N	109.00
						Respiratory 4.00	
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	
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
						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				0115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.		N				116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.		N				117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.				1		118.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-1318	Period: From 01/01/2022 To 12/31/2022	Worksheet S-2 Part I Date/Time Prepared: 5/31/2023 3:43 pm
		Premiums	Losses	Insurance
		1.00	2.00	3.00
118.01	List amounts of malpractice premiums and paid losses:	19,390	14,013	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 SYSTEMS, INC.	Contractor's Name: WPS	Contractor's Number: 52280	141.00
142.00	Street: 4000 MERIDIAN BLVD	PO Box:		142.00
143.00	City: FRANKLIN	State: TN	Zip Code: 37067	143.00
			1.00	
144.00	Are provider based physicians' costs included in Worksheet A?		Y	144.00
		1.00	2.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.			145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.		N	146.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-1318		Period: From 01/01/2022 To 12/31/2022		Worksheet S-2 Part I Date/Time Prepared: 5/31/2023 3:43 pm		
1.00								
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.						N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.						N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.						N	149.00
		Part A	Part B	Title V	Title XIX			
		1.00	2.00	3.00	4.00			
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)								
155.00	Hospital	N	N	N	N	N	155.00	
156.00	Subprovider - IPF	N	N	N	N	N	156.00	
157.00	Subprovider - IRF	N	N	N	N	N	157.00	
158.00	SUBPROVIDER						158.00	
159.00	SNF	N	N	N	N	N	159.00	
160.00	HOME HEALTH AGENCY	N	N	N	N	N	160.00	
161.00	CMHC		N	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)						0.00	169.00
		Beginning	Ending					
		1.00	2.00					
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)							170.00
		1.00	2.00					
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. 1, 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: 15-1318		Period: From 01/01/2022 To 12/31/2022		Worksheet S-2 Part II Date/Time Prepared: 5/31/2023 3:43 pm	
		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.	N					4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N					5.00
		Y/N	Legal Oper.				
		1.00	2.00				
Approved Educational Activities							
6.00	Column 1: Are costs claimed for a nursing program? Column 2: If yes, is the provider the legal operator of the program?	N					6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N					7.00
8.00	Were nursing programs and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N					8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N					9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N					10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N					11.00
		Y/N					
		1.00					
Bad Debts							
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.					Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.					N	13.00
14.00	If line 12 is yes, were patient deductibles and/or coinsurance amounts waived? If yes, see instructions.					N	14.00
Bed Complement							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.					N	15.00
		Part A		Part B			
		Y/N	Date	Y/N	Date		
		1.00	2.00	3.00	4.00		
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	04/17/2023	Y	04/17/2023		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N			17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N			19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-1318	Period: From 01/01/2022 To 12/31/2022	Worksheet S-2 Part II Date/Time Prepared: 5/31/2023 3:43 pm	
		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N	N		21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions		N		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		N		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		N		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		N		25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		N		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		N		27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		N		28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions		N		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		N		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		N		31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		N		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		N		33.00
Provider-Based Physicians					
34.00	Were services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		Y		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		Y		35.00
			Y/N	Date	
			1.00	2.00	
Home Office Costs					
36.00	Were home office costs claimed on the cost report?		Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		Y		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		Y	12/31/2021	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N		40.00
		1.00		2.00	
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	KUZI WA		TSI GA	41.00
42.00	Enter the employer/company name of the cost report preparer.	COMMUNITY HEALTH SYSTEMS, INC			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	615-465-3416		KUZI WA_TSI GA@CHS. NET	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-1318	Period: From 01/01/2022 To 12/31/2022	Worksheet S-2 Part II Date/Time Prepared: 5/31/2023 3:43 pm
		3.00		
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	MANAGER, REVENUE MANAGEMENT		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: 15-1318

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

Worksheet S-3
Part I
Date/Time Prepared:
5/31/2023 3:43 pm

Component	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P	Title V
	Line No.				Visits / Trips	
	1.00	2.00	3.00	4.00	5.00	
PART I - STATISTICAL DATA						
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	21	7,665	69,601.00	0	1.00
2.00 HMO and other (see instructions)						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		21	7,665	69,601.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	4	1,460	9,695.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		25	9,125	79,296.00	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)		25				27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00
33.01 LTCH site neutral days and discharges						33.01
34.00 Temporary Expansion COVID-19 PHE Acute Care	30.00	0	0		0	34.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 15-1318

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

Worksheet S-3
Part I
Date/Time Prepared:
5/31/2023 3:43 pm

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)	1,122	51	2,900		1.00
2.00	HMO and other (see instructions)	722	756			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	885	19	1,472		5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	21		6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	2,007	70	4,393		7.00
8.00	INTENSIVE CARE UNIT	195	2	404		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		21	234		13.00
14.00	Total (see instructions)	2,202	93	5,031	0.00	197.53
15.00	CAH visits	0	0	0		15.00
16.00	SUBPROVIDER - IPF					16.00
17.00	SUBPROVIDER - IRF					17.00
18.00	SUBPROVIDER					18.00
19.00	SKILLED NURSING FACILITY					19.00
20.00	NURSING FACILITY					20.00
21.00	OTHER LONG TERM CARE					21.00
22.00	HOME HEALTH AGENCY					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)					23.00
24.00	HOSPICE					24.00
24.10	HOSPICE (non-distinct part)			0		24.10
25.00	CMHC - CMHC					25.00
26.00	RURAL HEALTH CLINIC					26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER				0.00	0.00
27.00	Total (sum of lines 14-26)	0	0	0	0.00	197.53
28.00	Observation Bed Days		0	568		28.00
29.00	Ambulance Trips	0				29.00
30.00	Employee discount days (see instruction)			134		30.00
31.00	Employee discount days - IRF			0		31.00
32.00	Labor & delivery days (see instructions)	0	0	0		32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0		32.01
33.00	LTCH non-covered days	0				33.00
33.01	LTCH site neutral days and discharges	0				33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care	0	0	0		34.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 15-1318

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

Worksheet S-3
Part I
Date/Time Prepared:
5/31/2023 3:43 pm

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	337	25	874	1.00
2.00	HMO and other (see instructions)			170	264		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	337	25	874	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 RELATED COSTS	Provider CCN: 15-1318	Period: From 01/01/2022 To 12/31/2022	Worksheet S-3 Part IV Date/Time Prepared: 5/31/2023 3:43 pm
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		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	263,422	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)	0	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	0	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)	1,641,645	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	350	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	5,461	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)	4,910	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	76,954	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	848,258	17.00
18.00	Medicare Taxes - Employers Portion Only	198,383	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	39,091	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	0	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	3,078,474	24.00
Part B - Other than Core Related Cost			
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		25.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 15-1318	Period: From 01/01/2022 To 12/31/2022	Worksheet S-10 Date/Time Prepared: 5/31/2023 3:43 pm
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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)		0.209653	1.00	
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		7,369,253	2.00	
3.00	Did you receive DSH or supplemental payments from Medicaid?			3.00	
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?			4.00	
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid		0	5.00	
6.00	Medicaid charges		48,911,375	6.00	
7.00	Medicaid cost (line 1 times line 6)		10,254,417	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)		2,885,164	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)		2,885,164	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)	2,145,611	0	2,145,611	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	449,834	0	449,834	21.00
22.00	Payments received from patients for amounts previously written off as charity care	1,717	0	1,717	22.00
23.00	Cost of charity care (line 21 minus line 22)	448,117	0	448,117	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)		3,136,885		26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		303,066		27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		466,256		27.01
28.00	Non-Medicare bad debt expense (see instructions)		2,670,629		28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		723,095		29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		1,171,212		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		4,056,376		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES		Provider CCN: 15-1318		Period: From 01/01/2022 To 12/31/2022		Worksheet A	
Date/Time Prepared: 5/31/2023 3:43 pm							
Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassification (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		1,094,770	1,094,770	1,037,893	2,132,663	1.00
2.00	00200		2,202,655	2,202,655	154,511	2,357,166	2.00
4.00	00400		74,484	178,216	2,020,935	2,199,151	4.00
5.01	00570	103,732	0	0	1,388,696	1,388,696	5.01
5.02	00590	0	0	0	-4,056,831	7,800,356	5.02
7.00	00700	1,632,359	10,224,828	11,857,187	578,094	2,577,366	7.00
8.00	00800	354,948	1,644,324	1,999,272	0	78,362	8.00
9.00	00900	0	78,362	78,362	-2,996	542,365	9.00
10.00	01000	394,037	151,324	545,361	-92,104	311,575	10.00
11.00	01100	229,334	174,345	403,679	86,781	86,781	11.00
13.00	01300	0	0	0	-3,145	389,676	13.00
14.00	01400	329,402	63,419	392,821	-105,075	276,446	14.00
15.00	01500	174,043	207,478	381,521	-1,185,294	590,943	15.00
16.00	01600	486,321	1,289,916	1,776,237	-310	303,854	16.00
17.00	01700	51,615	252,549	304,164	0	203,474	17.00
		179,587	23,887	203,474			
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000						
31.00	03100	3,332,735	1,360,617	4,693,352	-488,536	4,204,816	30.00
43.00	04300	520,448	231,215	751,663	27	751,690	31.00
		0	0	0	477,137	477,137	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000						
51.00	05100	432,844	556,840	989,684	-173,095	816,589	50.00
52.00	05200	245,744	148,514	394,258	0	394,258	51.00
53.00	05300	0	0	0	0	0	52.00
54.00	05400	0	283,868	283,868	0	283,868	53.00
54.01	05401	624,405	236,169	860,574	271,436	1,132,010	54.00
56.00	05600	100,631	80,248	180,879	-180,879	0	54.01
57.00	05700	74,672	73,385	148,057	-148,057	0	56.00
58.00	05800	53,119	148,311	201,430	-201,430	0	57.00
60.00	06000	86,534	223,875	310,409	-310,409	0	58.00
62.00	06200	963,156	1,017,202	1,980,358	-59,398	1,920,960	60.00
65.00	06500	0	58,427	58,427	0	58,427	62.00
66.00	06600	764,567	168,253	932,820	-43,532	889,288	65.00
67.00	06700	0	396,000	396,000	0	396,000	66.00
68.00	06800	0	226,129	226,129	0	226,129	67.00
69.00	06900	0	66,272	66,272	0	66,272	68.00
71.00	07100	205,738	23,256	228,994	-2,001	226,993	69.00
72.00	07200	0	0	0	3,740	3,740	71.00
73.00	07300	0	0	0	47,040	47,040	72.00
76.00	03610	0	0	0	1,043,736	1,043,736	73.00
		0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000						
91.00	09100	106,687	12,389	119,076	0	119,076	90.00
92.00	09200	4,086,083	1,479,883	5,565,966	-1,522	5,564,444	91.00
							92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500						
		406,744	303,757	710,501	-55,412	655,089	95.00
SPECIAL PURPOSE COST CENTERS							
118.00							
		15,939,485	24,576,951	40,516,436	0	40,516,436	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000						
192.00	19200	0	0	0	0	0	190.00
200.00		0	0	0	0	0	192.00
		15,939,485	24,576,951	40,516,436	0	40,516,436	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-1318

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

Worksheet A
Date/Time Prepared:
5/31/2023 3:43 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	419,796	2,552,459	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	92,654	2,449,820	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	2,199,151	4.00
5.01	00570	ADMINISTRATIVE	0	1,388,696	5.01
5.02	00590	ADMINISTRATIVE AND GENERAL	-115,156	7,685,200	5.02
7.00	00700	OPERATION OF PLANT	-17,986	2,559,380	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	78,362	8.00
9.00	00900	HOUSEKEEPING	0	542,365	9.00
10.00	01000	DIETARY	0	311,575	10.00
11.00	01100	CAFETERIA	-58,177	28,604	11.00
13.00	01300	NURSING ADMINISTRATION	-1,912	387,764	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	276,446	14.00
15.00	01500	PHARMACY	0	590,943	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-391	303,463	16.00
17.00	01700	SOCIAL SERVICE	0	203,474	17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-365,742	3,839,074	30.00
31.00	03100	INTENSIVE CARE UNIT	0	751,690	31.00
43.00	04300	NURSERY	0	477,137	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	816,589	50.00
51.00	05100	RECOVERY ROOM	0	394,258	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	-283,868	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,132,010	54.00
54.01	05401	ULTRASOUND	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	56.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MRI	0	0	58.00
60.00	06000	LABORATORY	0	1,920,960	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	58,427	62.00
65.00	06500	RESPIRATORY THERAPY	0	889,288	65.00
66.00	06600	PHYSICAL THERAPY	0	396,000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	226,129	67.00
68.00	06800	SPEECH PATHOLOGY	0	66,272	68.00
69.00	06900	ELECTROCARDIOLOGY	0	226,993	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	3,740	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	47,040	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,043,736	73.00
76.00	03610	SLEEP LAB	0	0	76.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	119,076	90.00
91.00	09100	EMERGENCY	-783,380	4,781,064	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	655,089	95.00
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-1,114,162	39,402,274	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-1,114,162	39,402,274	200.00

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
A - EMPLOYEE BENEFITS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	2,021,488	1.00
	TOTALS		0	2,021,488	
B - RENT AND LEASES					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	497,655	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	128,357	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
	TOTALS		0	626,012	
C - OTHER CAPITAL COSTS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	176,083	1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	364,155	2.00
3.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	26,154	3.00
	TOTALS		0	566,392	
D - REPAIRS AND MAINTENANCE					
1.00	OPERATION OF PLANT	7.00	0	572,198	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
	TOTALS		0	572,198	
E - CNO COSTS					
1.00	NURSING ADMINISTRATION	13.00	201,785	0	1.00
	TOTALS		201,785	0	
F - MEDICAL SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	3,740	1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	47,040	2.00
3.00	CENTRAL SERVICES & SUPPLY	14.00	0	25,545	3.00
4.00	INTENSIVE CARE UNIT	31.00	0	27	4.00
	TOTALS		0	76,352	
G - COST OF DRUGS/IV SOLUTIONS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	1,043,736	1.00
	TOTALS		0	1,043,736	
H - NURSERY					
1.00	NURSERY	43.00	351,526	125,611	1.00
	TOTALS		351,526	125,611	
I - CASE MANAGEMENT					
1.00	ADMINISTRATIVE AND GENERAL	5.02	159,307	44,042	1.00
	TOTALS		159,307	44,042	
J - MISC DEPARTMENTS					
1.00	ADMINISTRATIVE	5.01	553,544	835,152	1.00
	TOTALS		553,544	835,152	
K - OTHER RADIOLOGY					
1.00	RADIOLOGY-DIAGNOSTIC	54.00	314,956	109,474	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

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	TOTALS		314,956	109,474	
L - DIETARY COSTS TO CAFETERIA					
1.00	CAFETERIA	11.00	49,301	37,480	1.00
	TOTALS		49,301	37,480	
M - NON CAPITALIZED EQUIPMENT					
1.00	OPERATION OF PLANT	7.00	0	12,504	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
	TOTALS		0	12,504	
N - SITTER COSTS					
1.00	ADULTS & PEDIATRICS	30.00	1,446	112	1.00
	TOTALS		1,446	112	
500.00	Grand Total: Increases		1,631,865	6,070,553	500.00

RECLASSIFICATIONS

Provider CCN: 15-1318

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

Worksheet A-6
Date/Time Prepared:
5/31/2023 3:43 pm

		Decreases					
Cost Center		Line #	Salary	Other	Wkst. A-7 Ref.		
6.00		7.00	8.00	9.00	10.00		
A - EMPLOYEE BENEFITS							
1.00	ADMINISTRATIVE AND GENERAL	5.02	0	2,021,488	0		1.00
	TOTALS		0	2,021,488			
B - RENT AND LEASES							
1.00	ADMINISTRATIVE AND GENERAL	5.02	0	1,033	10		1.00
2.00	OPERATION OF PLANT	7.00	0	6,608	10		2.00
3.00	NURSING ADMINISTRATION	13.00	0	23	0		3.00
4.00	CENTRAL SERVICES & SUPPLY	14.00	0	114,244	0		4.00
5.00	PHARMACY	15.00	0	112,640	0		5.00
6.00	MEDICAL RECORDS & LIBRARY	16.00	0	310	0		6.00
7.00	ADULTS & PEDIATRICS	30.00	0	2,086	0		7.00
8.00	OPERATING ROOM	50.00	0	15,245	0		8.00
9.00	RADIOLOGY-DIAGNOSTIC	54.00	0	77,684	0		9.00
10.00	ULTRASOUND	54.01	0	33,243	0		10.00
11.00	CT SCAN	57.00	0	72,155	0		11.00
12.00	MRI	58.00	0	133,932	0		12.00
13.00	LABORATORY	60.00	0	10,322	0		13.00
14.00	RESPIRATORY THERAPY	65.00	0	39,772	0		14.00
15.00	ELECTROCARDIOLOGY	69.00	0	1,715	0		15.00
16.00	AMBULANCE SERVICES	95.00	0	5,000	0		16.00
	TOTALS		0	626,012			
C - OTHER CAPITAL COSTS							
1.00	ADMINISTRATIVE AND GENERAL	5.02	0	566,392	12		1.00
2.00		0.00	0	0	13		2.00
3.00		0.00	0	0	12		3.00
	TOTALS		0	566,392			
D - REPAIRS AND MAINTENANCE							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	553	0		1.00
2.00	ADMINISTRATIVE AND GENERAL	5.02	0	80,786	0		2.00
3.00	HOUSEKEEPING	9.00	0	2,996	0		3.00
4.00	DIETARY	10.00	0	5,323	0		4.00
5.00	CENTRAL SERVICES & SUPPLY	14.00	0	16,376	0		5.00
6.00	PHARMACY	15.00	0	19,501	0		6.00
7.00	ADULTS & PEDIATRICS	30.00	0	10,871	0		7.00
8.00	OPERATING ROOM	50.00	0	82,135	0		8.00
9.00	RADIOLOGY-DIAGNOSTIC	54.00	0	75,310	0		9.00
10.00	ULTRASOUND	54.01	0	39,214	0		10.00
11.00	RADIOISOTOPE	56.00	0	16,793	0		11.00
12.00	CT SCAN	57.00	0	46,890	0		12.00
13.00	MRI	58.00	0	74,118	0		13.00
14.00	LABORATORY	60.00	0	48,633	0		14.00
15.00	RESPIRATORY THERAPY	65.00	0	1,997	0		15.00
16.00	ELECTROCARDIOLOGY	69.00	0	286	0		16.00
17.00	EMERGENCY	91.00	0	770	0		17.00
18.00	AMBULANCE SERVICES	95.00	0	49,646	0		18.00
	TOTALS		0	572,198			
E - CNO COSTS							
1.00	ADMINISTRATIVE AND GENERAL	5.02	201,785	0	0		1.00
	TOTALS		201,785	0			
F - MEDICAL SUPPLIES							
1.00	OPERATING ROOM	50.00	0	75,551	0		1.00
2.00	RESPIRATORY THERAPY	65.00	0	49	0		2.00
3.00	EMERGENCY	91.00	0	752	0		3.00
4.00		0.00	0	0	0		4.00
	TOTALS		0	76,352			
G - COST OF DRUGS/IV SOLUTIONS							
1.00	PHARMACY	15.00	0	1,043,736	0		1.00
	TOTALS		0	1,043,736			
H - NURSERY							
1.00	ADULTS & PEDIATRICS	30.00	351,526	125,611	0		1.00
	TOTALS		351,526	125,611			
I - CASE MANAGEMENT							
1.00	NURSING ADMINISTRATION	13.00	159,307	44,042	0		1.00
	TOTALS		159,307	44,042			
J - MISC DEPARTMENTS							
1.00	ADMINISTRATIVE AND GENERAL	5.02	553,544	835,152	0		1.00
	TOTALS		553,544	835,152			
K - OTHER RADIOLOGY							
1.00	ULTRASOUND	54.01	100,631	7,791	0		1.00
2.00	RADIOISOTOPE	56.00	74,672	56,592	0		2.00
3.00	CT SCAN	57.00	53,119	29,266	0		3.00
4.00	MRI	58.00	86,534	15,825	0		4.00
	TOTALS		314,956	109,474			

Decreases							
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	L - DIETARY COSTS TO CAFETERIA						
1.00	DIETARY	10.00	49,301	37,480	0	1.00	
	TOTALS		49,301	37,480			
	M - NON CAPITALIZED EQUIPMENT						
1.00	PHARMACY	15.00	0	9,417	0	1.00	
2.00	OPERATING ROOM	50.00	0	164	0	2.00	
3.00	LABORATORY	60.00	0	443	0	3.00	
4.00	RESPIRATORY THERAPY	65.00	0	1,714	0	4.00	
5.00	AMBULANCE SERVICES	95.00	0	766	0	5.00	
	TOTALS		0	12,504			
	N - SITTER COSTS						
1.00	NURSING ADMINISTRATION	13.00	1,446	112	0	1.00	
	TOTALS		1,446	112			
500.00	Grand Total: Decreases		1,631,865	6,070,553		500.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-1318

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

Worksheet A-7
Part I
Date/Time Prepared:
5/31/2023 3:43 pm

	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
		1.00	2.00	3.00		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	193,225	0	0	0	1.00
2.00	Land Improvements	1,038,384	0	0	0	2.00
3.00	Buildings and Fixtures	28,751,975	724,540	0	724,540	3.00
4.00	Building Improvements	31,950,293	1,772,690	0	1,772,690	4.00
5.00	Fixed Equipment	0	0	0	0	5.00
6.00	Movable Equipment	0	0	0	0	6.00
7.00	HIT designated Assets	4,592,929	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	66,526,806	2,497,230	0	2,497,230	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	66,526,806	2,497,230	0	2,497,230	10.00
	Ending Balance		Fully Depreciated Assets			
		6.00	7.00			
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	193,225	0			1.00
2.00	Land Improvements	1,038,384	0			2.00
3.00	Buildings and Fixtures	29,476,515	0			3.00
4.00	Building Improvements	33,715,391	0			4.00
5.00	Fixed Equipment	0	0			5.00
6.00	Movable Equipment	0	0			6.00
7.00	HIT designated Assets	4,592,929	0			7.00
8.00	Subtotal (sum of lines 1-7)	69,016,444	0			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	69,016,444	0			10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-1318

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

Worksheet A-7
Part II
Date/Time Prepared:
5/31/2023 3:43 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	1,094,770	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2,202,655	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	3,297,425	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	1,094,770				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	2,202,655				2.00
3.00	Total (sum of lines 1-2)	0	3,297,425				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-1318

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

Worksheet A-7
Part III
Date/Time Prepared:
5/31/2023 3:43 pm

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	64,423,514	0	64,423,514	0.933452	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	4,592,929	0	4,592,929	0.066548	0	2.00
3.00	Total (sum of lines 1-2)	69,016,443	0	69,016,443	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1,474,795	533,990	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	2,218,284	204,664	2.00
3.00	Total (sum of lines 1-2)	0	0	0	3,693,079	738,654	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	3,436	176,083	364,155	0	2,552,459	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	718	26,154	0	0	2,449,820	2.00
3.00	Total (sum of lines 1-2)	4,154	202,237	364,155	0	5,002,279	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 15-1318

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

Worksheet A-8

Date/Time Prepared:
5/31/2023 3:43 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted				
			Cost Center		Line #	Wkst. A-7 Ref.	
			1.00	2.00	3.00	4.00	5.00
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00 Investment income - other (chapter 2)			0		0.00	0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)			0		0.00	0	4.00
5.00 Refunds and rebates of expenses (chapter 8)			0		0.00	0	5.00
6.00 Rental of provider space by suppliers (chapter 8)			0		0.00	0	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)			0		0.00	0	7.00
8.00 Television and radio service (chapter 21)	A	-17,986	0	OPERATION OF PLANT	7.00	0	8.00
9.00 Parking lot (chapter 21)			0		0.00	0	9.00
10.00 Provider-based physician adjustment	A-8-2	-1,432,990	0			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	-58,917	0			0	12.00
13.00 Laundry and linen service			0		0.00	0	13.00
14.00 Cafeteria-employees and guests	B	-57,954	0	CAFETERIA	11.00	0	14.00
15.00 Rental of quarters to employee and others			0		0.00	0	15.00
16.00 Sale of medical and surgical supplies to other than patients			0		0.00	0	16.00
17.00 Sale of drugs to other than patients			0		0.00	0	17.00
18.00 Sale of medical records and abstracts	B	-391	0	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00 Nursing and allied health education (tuition, fees, books, etc.)			0		0.00	0	19.00
20.00 Vending machines			0		0.00	0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)			0		0.00	0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments			0		0.00	0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	0	RESPIRATORY THERAPY	65.00		23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	0	PHYSICAL THERAPY	66.00		24.00
25.00 Utilization review - physicians' compensation (chapter 21)			0	*** Cost Center Deleted ***	114.00		25.00
26.00 Depreciation - CAP REL COSTS-BLDG & FIXT	A	1,269	0	CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP	A	-2,797	0	CAP REL COSTS-MVBLE EQUIP	2.00	9	27.00
28.00 Non-physician Anesthetist			0	*** Cost Center Deleted ***	19.00		28.00
29.00 Physicians' assistant			0		0.00	0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	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	0	SPEECH PATHOLOGY	68.00		31.00
32.00 CAH HIT Adjustment for Depreciation and Interest			0		0.00	0	32.00
33.00 TRAINING REVENUE	B	-1,030	0	NURSING ADMINISTRATION	13.00	0	33.00

Provider CCN: 15-1318
 Period: From 01/01/2022 To 12/31/2022
 Worksheet A-8
 Date/Time Prepared: 5/31/2023 3:43 pm

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	4.00	5.00
33.01 FITNESS REVENUE	B	-105	ADMINISTRATIVE AND GENERAL	5.02	0 33.01
33.02 MISCELLANEOUS INCOME	B	2,069	ADMINISTRATIVE AND GENERAL	5.02	0 33.02
33.03 COFFEE SHOP REVENUE	B	-223	CAFETERIA	11.00	0 33.03
33.05 EMPLOYEE SELF INS DISCOUNTS	B	38,134	ADMINISTRATIVE AND GENERAL	5.02	0 33.05
33.06 INSERVICE EDUCATION	B	-882	NURSING ADMINISTRATION	13.00	0 33.06
33.07 POB CAPITAL RELATED EXPENSE	A	378,756	CAP REL COSTS-BLDG & FIXT	1.00	9 33.07
33.08 POB CAPITAL RELATED EXPENSE	A	19,809	CAP REL COSTS-MVBLE EQUIP	2.00	9 33.08
33.09 CHARITABLE CONTRIBUTIONS	A	-452	ADMINISTRATIVE AND GENERAL	5.02	0 33.09
33.10 PATIENT TV DEPRECIATION	A	-1,383	CAP REL COSTS-MVBLE EQUIP	2.00	9 33.10
33.11 ANTHEMER SETTLEMENT	A	35,629	ADMINISTRATIVE AND GENERAL	5.02	0 33.11
34.00 INTEREST INCOME ADD BACK	B	2,092	ADMINISTRATIVE AND GENERAL	5.02	0 34.00
35.00 MARKETING EXPENSE	A	-16,792	ADMINISTRATIVE AND GENERAL	5.02	0 35.00
36.00 LOBBYING EXPENSE	A	-18	ADMINISTRATIVE AND GENERAL	5.02	0 36.00
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-1,114,162			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: 15-1318

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

Worksheet A-8-1

Date/Time Prepared: 5/31/2023 3:43 pm

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	0.00	PASI CAPITAL COSTS - BLDG &	0	0	1.00
2.00	0.00	PASI CAPITAL COSTS - MOVEABL	0	0	2.00
3.00	1.00	CAP REL COSTS-BLDG & FIXT	3,436	0	3.00
3.02	2.00	CAP REL COSTS-MVBLE EQUIP	718	0	3.02
3.04	5.02	ADMINISTRATIVE AND GENERAL	245,460	202,509	3.04
4.00	5.02	ADMINISTRATIVE AND GENERAL	1,004,294	743,100	4.00
4.01	1.00	CAP REL COSTS-BLDG & FIXT	36,335	0	4.01
4.02	2.00	CAP REL COSTS-MVBLE EQUIP	76,307	0	4.02
4.03	5.02	ADMINISTRATIVE AND GENERAL	1,420,289	0	4.03
4.04	5.02	ADMINISTRATIVE AND GENERAL	33,403	171,061	4.04
4.05	5.02	ADMINISTRATIVE AND GENERAL	0	937,494	4.05
4.06	5.02	ADMINISTRATIVE AND GENERAL	0	4,900	4.06
4.07	5.02	ADMINISTRATIVE AND GENERAL	0	25,918	4.07
4.08	5.02	ADMINISTRATIVE AND GENERAL	0	545,879	4.08
4.09	5.02	ADMINISTRATIVE AND GENERAL	0	164,862	4.09
4.10	5.02	ADMINISTRATIVE AND GENERAL	0	76,445	4.10
4.11	5.02	ADMINISTRATIVE AND GENERAL	0	6,991	4.11
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.		2,820,242	2,879,159	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	Related Organization(s) and/or Home Office	
			Name	Percentage of Ownership
1.00	2.00	3.00	4.00	5.00
B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:				

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

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

6.00	B	0.00	COMMUNITY HEALTH SYTEMS	100.00	6.00
7.00	B	0.00	PASI	100.00	7.00
8.00	B	0.00	HOSPITAL LAUNDRY SERVICE	100.00	8.00
9.00		0.00		0.00	9.00
10.00		0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:				100.00

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

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

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

Provider CCN: 15-1318

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

Worksheet A-8-1

Date/Time Prepared:
5/31/2023 3:43 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.	
	6.00	7.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	0	0	1.00
2.00	0	0	2.00
3.00	3,436	11	3.00
3.02	718	11	3.02
3.04	42,951	0	3.04
4.00	261,194	0	4.00
4.01	36,335	10	4.01
4.02	76,307	10	4.02
4.03	1,420,289	0	4.03
4.04	-137,658	0	4.04
4.05	-937,494	0	4.05
4.06	-4,900	0	4.06
4.07	-25,918	0	4.07
4.08	-545,879	0	4.08
4.09	-164,862	0	4.09
4.10	-76,445	0	4.10
4.11	-6,991	0	4.11
5.00	-58,917		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	HOSPITAL MANAGEMENT	6.00
7.00	DEBT COLLECTION	7.00
8.00	LAUNDRY SERVICE	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: 15-1318

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

Worksheet A-8-2

Date/Time Prepared:
5/31/2023 3:43 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	365,742	365,742	0	0	0	1.00
2.00	53.00	ANESTHESIOLOGY	283,868	283,868	0	0	0	2.00
3.00	91.00	EMERGENCY	2,335,551	783,380	1,552,171	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			2,985,161	1,432,990	1,552,171			200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	2.00
3.00	91.00	EMERGENCY	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	30.00	ADULTS & PEDIATRICS	0	0	0	365,742		1.00
2.00	53.00	ANESTHESIOLOGY	0	0	0	283,868		2.00
3.00	91.00	EMERGENCY	0	0	0	783,380		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	1,432,990		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 15-1318		Period: From 01/01/2022 To 12/31/2022		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 5/31/2023 3:43 pm	
		Physical Therapy		Cost			
				1.00			
PART I - GENERAL INFORMATION							
1.00	Total number of weeks worked (excluding aides) (see instructions)					0	1.00
2.00	Line 1 multiplied by 15 hours per week					0	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					0	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					0.00	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	1,814.17	2,494.16	1,621.78	1,158.33	0.00	9.00
10.00	AHSEA (see instructions)	84.94	84.94	50.50	17.50	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	42.47	42.47	25.25			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
Part II - SALARY EQUIVALENCY COMPUTATION							
14.00	Supervisors (column 1, line 9 times column 1, line 10)					154,096	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					211,854	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)					81,900	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					447,850	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					20,271	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					468,121	20.00
If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.							
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					0	22.00
23.00	Total salary equivalency (see instructions)					468,121	23.00
Part III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE							
Standard Travel Allowance							
24.00	Therapists (line 3 times column 2, line 11)					0	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					0	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					0	28.00
Optional Travel Allowance and Optional Travel Expense							
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					0	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE							
Standard Travel Expense							
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
Optional Travel Allowance and Optional Travel Expense							
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.							
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 15-1318				Period: From 01/01/2022 To 12/31/2022		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 5/31/2023 3:43 pm	
		Physical Therapy				Cost			
						1.00			
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0		46.00	
		Therapists	Assistants	Aides	Trainees	Total			
		1.00	2.00	3.00	4.00	5.00			
PART V - OVERTIME COMPUTATION									
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00		47.00	
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00	0.00		48.00	
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00	0.00		49.00	
CALCULATION OF LIMIT									
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00		50.00	
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50 (see instructions)	0.00	0.00	0.00	0.00	0.00		51.00	
DETERMINATION OF OVERTIME ALLOWANCE									
52.00	Adjusted hourly salary equivalency amount (see instructions)	84.94	50.50	17.50	0.00			52.00	
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0			53.00	
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0			54.00	
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0			55.00	
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0		56.00	
						1.00			
Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT									
57.00	Salary equivalency amount (from line 23)					468,121		57.00	
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))					0		58.00	
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)					0		59.00	
60.00	Overtime allowance (from column 5, line 56)					0		60.00	
61.00	Equipment cost (see instructions)					0		61.00	
62.00	Supplies (see instructions)					0		62.00	
63.00	Total allowance (sum of lines 57-62)					468,121		63.00	
64.00	Total cost of outside supplier services (from your records)					374,446		64.00	
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)					0		65.00	
LINE 33 CALCULATION									
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others					0		100.00	
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					0		100.01	
100.02	Line 33 = line 28 = sum of lines 26 and 27					0		100.02	
LINE 34 CALCULATION									
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					0		101.00	
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					0		101.01	
101.02	Line 34 = sum of lines 27 and 31					0		101.02	
LINE 35 CALCULATION									
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					0		102.00	
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others					0		102.01	
102.02	Line 35 = sum of lines 31 and 32					0		102.02	

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 15-1318		Period: From 01/01/2022 To 12/31/2022		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 5/31/2023 3:43 pm	
				Occupational Therapy		Cost	
						1.00	
PART I - GENERAL INFORMATION							
1.00	Total number of weeks worked (excluding aides) (see instructions)					0	1.00
2.00	Line 1 multiplied by 15 hours per week					0	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					0	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					0.00	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	1,068.17	984.35	1,632.71	0.00	0.00	9.00
10.00	AHSEA (see instructions)	80.52	80.52	50.50	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	40.26	40.26	25.25			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
Part II - SALARY EQUIVALENCY COMPUTATION							
14.00	Supervisors (column 1, line 9 times column 1, line 10)					86,009	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					79,260	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)					82,452	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					247,721	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					247,721	20.00
If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.							
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					0	22.00
23.00	Total salary equivalency (see instructions)					247,721	23.00
PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE							
Standard Travel Allowance							
24.00	Therapists (line 3 times column 2, line 11)					0	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					0	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					0	28.00
Optional Travel Allowance and Optional Travel Expense							
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					0	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE							
Standard Travel Expense							
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
Optional Travel Allowance and Optional Travel Expense							
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.							
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 15-1318		Period: From 01/01/2022 To 12/31/2022		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 5/31/2023 3:43 pm	
				Occupational Therapy		Cost	
						1.00	
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
PART V - OVERTIME COMPUTATION							
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
CALCULATION OF LIMIT							
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
DETERMINATION OF OVERTIME ALLOWANCE							
52.00	Adjusted hourly salary equivalency amount (see instructions)	80.52	50.50	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00
						1.00	
Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT							
57.00	Salary equivalency amount (from line 23)					247,721	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))					0	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)					0	59.00
60.00	Overtime allowance (from column 5, line 56)					0	60.00
61.00	Equipment cost (see instructions)					0	61.00
62.00	Supplies (see instructions)					0	62.00
63.00	Total allowance (sum of lines 57-62)					247,721	63.00
64.00	Total cost of outside supplier services (from your records)					226,129	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)					0	65.00
LINE 33 CALCULATION							
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others					0	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					0	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27					0	100.02
LINE 34 CALCULATION							
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					0	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					0	101.01
101.02	Line 34 = sum of lines 27 and 31					0	101.02
LINE 35 CALCULATION							
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others					0	102.01
102.02	Line 35 = sum of lines 31 and 32					0	102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 15-1318		Period: From 01/01/2022 To 12/31/2022		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 5/31/2023 3:43 pm	
		Speech Pathology		Cost			
						1.00	
PART I - GENERAL INFORMATION							
1.00	Total number of weeks worked (excluding aides) (see instructions)					0	1.00
2.00	Line 1 multiplied by 15 hours per week					0	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					0	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					0.00	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	971.55	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	77.39	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	38.70	38.70	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
Part II - SALARY EQUIVALENCY COMPUTATION							
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					75,188	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)					0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					75,188	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					75,188	20.00
If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.							
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					0	22.00
23.00	Total salary equivalency (see instructions)					75,188	23.00
PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE							
Standard Travel Allowance							
24.00	Therapists (line 3 times column 2, line 11)					0	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					0	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					0	28.00
Optional Travel Allowance and Optional Travel Expense							
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					0	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
PART IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE							
Standard Travel Expense							
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
Optional Travel Allowance and Optional Travel Expense							
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.							
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 15-1318				Period: From 01/01/2022 To 12/31/2022		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 5/31/2023 3:43 pm	
		Speech Pathology				Cost			
						1.00			
46.00 Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)						0		46.00	
		Therapists	Assistants	Aides	Trainees	Total			
		1.00	2.00	3.00	4.00	5.00			
PART V - OVERTIME COMPUTATION									
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00		47.00	
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00	0.00		48.00	
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00	0.00		49.00	
CALCULATION OF LIMIT									
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00		50.00	
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50 (see instructions)	0.00	0.00	0.00	0.00	0.00		51.00	
DETERMINATION OF OVERTIME ALLOWANCE									
52.00	Adjusted hourly salary equivalency amount (see instructions)	77.39	0.00	0.00	0.00			52.00	
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0			53.00	
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0			54.00	
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0			55.00	
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0			56.00	
						1.00			
Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT									
57.00	Salary equivalency amount (from line 23)					75,188		57.00	
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35)					0		58.00	
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)					0		59.00	
60.00	Overtime allowance (from column 5, line 56)					0		60.00	
61.00	Equipment cost (see instructions)					0		61.00	
62.00	Supplies (see instructions)					0		62.00	
63.00	Total allowance (sum of lines 57-62)					75,188		63.00	
64.00	Total cost of outside supplier services (from your records)					66,273		64.00	
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)					0		65.00	
LINE 33 CALCULATION									
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others					0		100.00	
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					0		100.01	
100.02	Line 33 = line 28 = sum of lines 26 and 27					0		100.02	
LINE 34 CALCULATION									
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					0		101.00	
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					0		101.01	
101.02	Line 34 = sum of lines 27 and 31					0		101.02	
LINE 35 CALCULATION									
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					0		102.00	
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others					0		102.01	
102.02	Line 35 = sum of lines 31 and 32					0		102.02	

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-1318

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

Worksheet B
Part I
Date/Time Prepared:
5/31/2023 3:43 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst Allocation)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	ADMITTING	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	2,552,459	2,552,459			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	2,449,820		2,449,820		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	2,199,151	11,644	11,176	2,221,971	4.00
5.01 00570	ADMITTING	1,388,696	18,760	18,006	77,670	1,503,132 5.01
5.02 00590	ADMINISTRATIVE AND GENERAL	7,685,200	157,818	151,472	145,413	0 5.02
7.00 00700	OPERATION OF PLANT	2,559,380	692,002	664,177	49,804	0 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	78,362	30,154	28,941	0	0 8.00
9.00 00900	HOUSEKEEPING	542,365	29,111	27,940	55,289	0 9.00
10.00 01000	DIETARY	311,575	37,428	35,923	25,261	0 10.00
11.00 01100	CAFETERIA	28,604	33,613	32,261	6,918	0 11.00
13.00 01300	NURSING ADMINISTRATION	387,764	9,241	8,870	51,977	0 13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	276,446	46,947	45,059	24,421	0 14.00
15.00 01500	PHARMACY	590,943	27,117	26,027	68,238	0 15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	303,463	43,884	42,119	7,242	0 16.00
17.00 01700	SOCIAL SERVICE	203,474	11,407	10,948	25,199	0 17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	3,839,074	361,923	347,369	418,508	96,807 30.00
31.00 03100	INTENSIVE CARE UNIT	751,690	45,521	43,690	73,026	12,310 31.00
43.00 04300	NURSERY	477,137	9,888	9,491	49,324	1,831 43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	816,589	171,403	164,511	60,734	128,279 50.00
51.00 05100	RECOVERY ROOM	394,258	13,493	12,950	34,481	26,740 51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0 52.00
53.00 05300	ANESTHESIOLOGY	0	0	0	0	0 53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	1,132,010	144,444	138,636	131,805	299,230 54.00
54.01 05401	ULTRASOUND	0	0	0	0	0 54.01
56.00 05600	RADIOISOTOPE	0	0	0	0	0 56.00
57.00 05700	CT SCAN	0	0	0	0	0 57.00
58.00 05800	MRI	0	0	0	0	0 58.00
60.00 06000	LABORATORY	1,920,960	40,544	38,913	135,144	207,231 60.00
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELL	58,427	1,558	1,495	0	3,927 62.00
65.00 06500	RESPIRATORY THERAPY	889,288	40,966	39,319	107,279	48,479 65.00
66.00 06600	PHYSICAL THERAPY	396,000	116,892	112,191	0	21,358 66.00
67.00 06700	OCCUPATIONAL THERAPY	226,129	3,182	3,054	0	13,524 67.00
68.00 06800	SPEECH PATHOLOGY	66,272	0	0	0	1,823 68.00
69.00 06900	ELECTROCARDIOLOGY	226,993	53,667	51,509	28,868	58,709 69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,740	0	0	0	24,991 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	47,040	0	0	0	2,288 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	1,043,736	0	0	0	210,860 73.00
76.00 03610	SLEEP LAB	0	0	0	0	0 76.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	119,076	35,883	34,440	14,970	1,268 90.00
91.00 09100	EMERGENCY	4,781,064	97,286	93,374	573,328	248,268 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART					
OTHER REIMBURSABLE COST CENTERS						
95.00 09500	AMBULANCE SERVICES	655,089	33,758	32,400	57,072	95,209 95.00
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	39,402,274	2,319,534	2,226,261	2,221,971	1,503,132 118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	10,377	9,960	0	0 190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	222,548	213,599	0	0 192.00
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers		0	0	0	0 201.00
202.00	TOTAL (sum lines 118 through 201)	39,402,274	2,552,459	2,449,820	2,221,971	1,503,132 202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-1318

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

Worksheet B
Part I
Date/Time Prepared:
5/31/2023 3:43 pm

Cost Center Description		Subtotal	ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		5A. 01	5. 02	7. 00	8. 00	9. 00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00570	ADMINISTRATIVE					5.01
5.02	00590	ADMINISTRATIVE AND GENERAL	8,139,903	8,139,903			5.02
7.00	00700	OPERATION OF PLANT	3,965,363	1,032,477	4,997,840		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	137,457	35,790	103,956	277,203	8.00
9.00	00900	HOUSEKEEPING	654,705	170,468	100,360	0	925,533
10.00	01000	DIETARY	410,187	106,802	129,034	0	25,534
11.00	01100	CAFETERIA	101,396	26,401	115,881	0	22,931
13.00	01300	NURSING ADMINISTRATION	457,852	119,213	31,860	0	6,305
14.00	01400	CENTRAL SERVICES & SUPPLY	392,873	102,294	161,851	0	32,028
15.00	01500	PHARMACY	712,325	185,471	93,487	0	18,500
16.00	01600	MEDICAL RECORDS & LIBRARY	396,708	103,292	151,291	0	29,938
17.00	01700	SOCIAL SERVICE	251,028	65,361	39,325	0	7,782
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	5,063,681	1,318,451	1,247,741	227,216	246,907
31.00	03100	INTENSIVE CARE UNIT	926,237	241,168	156,935	31,653	31,055
43.00	04300	NURSERY	547,671	142,599	34,091	18,334	6,746
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,341,516	349,296	590,918	0	116,933
51.00	05100	RECOVERY ROOM	481,922	125,480	46,516	0	9,205
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,846,125	480,683	497,977	0	98,542
54.01	05401	ULTRASOUND	0	0	0	0	0
56.00	05600	RADIOISOTOPE	0	0	0	0	0
57.00	05700	CT SCAN	0	0	0	0	0
58.00	05800	MRI	0	0	0	0	0
60.00	06000	LABORATORY	2,342,792	610,002	139,776	0	27,659
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	65,407	17,030	5,371	0	1,063
65.00	06500	RESPIRATORY THERAPY	1,125,331	293,007	141,232	0	27,948
66.00	06600	PHYSICAL THERAPY	646,441	168,316	402,988	0	79,745
67.00	06700	OCCUPATIONAL THERAPY	245,889	64,023	10,969	0	2,171
68.00	06800	SPEECH PATHOLOGY	68,095	17,730	0	0	0
69.00	06900	ELECTROCARDIOLOGY	419,746	109,291	185,018	0	36,612
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	28,731	7,481	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	49,328	12,844	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	1,254,596	326,664	0	0	0
76.00	03610	SLEEP LAB	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	205,637	53,543	123,709	0	24,480
91.00	09100	EMERGENCY	5,793,320	1,508,426	335,398	0	66,370
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0				
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	873,528	227,444	116,381	0	0
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	38,945,790	8,021,047	4,962,065	277,203	918,454
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	20,337	5,295	35,775	0	7,079
192.00	19200	PHYSICIANS' PRIVATE OFFICES	436,147	113,561	0	0	0
200.00		Cross Foot Adjustments	0	0	0	0	0
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118 through 201)	39,402,274	8,139,903	4,997,840	277,203	925,533

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 15-1318	Period: From 01/01/2022 To 12/31/2022	Worksheet B Part I Date/Time Prepared: 5/31/2023 3:43 pm
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Cost Center Description		DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		10.00	11.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00570						5.01
5.02	00590						5.02
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000	671,557					10.00
11.00	01100	0	266,609				11.00
13.00	01300	0	5,891	621,121			13.00
14.00	01400	0	7,405	0	696,451		14.00
15.00	01500	0	8,646	0	25,972	1,044,401	15.00
16.00	01600	0	2,152	0	87	0	16.00
17.00	01700	0	4,286	0	4	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	599,080	64,769	333,761	84,825	0	30.00
31.00	03100	72,477	6,311	62,831	8,751	0	31.00
43.00	04300	0	5,144	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	8,974	30,550	116,256	0	50.00
51.00	05100	0	4,432	28,874	8,235	0	51.00
52.00	05200	0	0	0	0	0	52.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	0	24,788	2,658	34,299	0	54.00
54.01	05401	0	0	0	0	0	54.01
56.00	05600	0	0	0	0	0	56.00
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
60.00	06000	0	29,950	15	221,612	0	60.00
62.00	06200	0	0	0	31,045	0	62.00
65.00	06500	0	16,926	8	35,651	0	65.00
66.00	06600	0	0	0	1,428	0	66.00
67.00	06700	0	0	0	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
69.00	06900	0	4,961	0	3,015	0	69.00
71.00	07100	0	0	0	4,791	0	71.00
72.00	07200	0	0	0	25,668	0	72.00
73.00	07300	0	0	0	0	1,044,401	73.00
76.00	03610	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	2,098	11,847	2,277	0	90.00
91.00	09100	0	25,590	150,534	49,382	0	91.00
92.00	09200	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	0	44,286	43	43,153	0	95.00
SPECIAL PURPOSE COST CENTERS							
118.00		671,557	266,609	621,121	696,451	1,044,401	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	0	0	0	0	192.00
200.00		0	0	0	0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		671,557	266,609	621,121	696,451	1,044,401	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-1318

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

Worksheet B
Part I
Date/Time Prepared:
5/31/2023 3:43 pm

Cost Center Description		MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		16.00	17.00	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
5.01	00570	ADMITTING					5.01
5.02	00590	ADMINISTRATIVE AND GENERAL					5.02
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	683,468				16.00
17.00	01700	SOCIAL SERVICE	0	367,786			17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	44,025	301,464	9,531,920	0	9,531,920
31.00	03100	INTENSIVE CARE UNIT	5,598	41,997	1,585,013	0	1,585,013
43.00	04300	NURSERY	833	24,325	779,743	0	779,743
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	58,337	0	2,612,780	0	2,612,780
51.00	05100	RECOVERY ROOM	12,161	0	716,825	0	716,825
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	135,970	0	3,121,042	0	3,121,042
54.01	05401	ULTRASOUND	0	0	0	0	54.01
56.00	05600	RADIOLOGY	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	58.00
60.00	06000	LABORATORY	94,242	0	3,466,048	0	3,466,048
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	1,786	0	121,702	0	121,702
65.00	06500	RESPIRATORY THERAPY	22,047	0	1,662,150	0	1,662,150
66.00	06600	PHYSICAL THERAPY	9,713	0	1,308,631	0	1,308,631
67.00	06700	OCCUPATIONAL THERAPY	6,150	0	329,202	0	329,202
68.00	06800	SPEECH PATHOLOGY	829	0	86,654	0	86,654
69.00	06900	ELECTROCARDIOLOGY	26,699	0	785,342	0	785,342
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	11,365	0	52,368	0	52,368
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,041	0	88,881	0	88,881
73.00	07300	DRUGS CHARGED TO PATIENTS	95,893	0	2,721,554	0	2,721,554
76.00	03610	SLEEP LAB	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	577	0	424,168	0	424,168
91.00	09100	EMERGENCY	112,904	0	8,041,924	0	8,041,924
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	43,298	0	1,348,133	0	1,348,133
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	683,468	367,786	38,784,080	0	38,784,080
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	68,486	0	68,486
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	549,708	0	549,708
200.00		Cross Foot Adjustments			0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	683,468	367,786	39,402,274	0	39,402,274

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-1318

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

Worksheet B
Part II
Date/Time Prepared:
5/31/2023 3:43 pm

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	11,644	11,176	22,820	4.00
5.01 00570	ADMINISTRATIVE	0	18,760	18,006	36,766	5.01
5.02 00590	ADMINISTRATIVE AND GENERAL	0	157,818	151,472	309,290	5.02
7.00 00700	OPERATION OF PLANT	0	692,002	664,177	1,356,179	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	30,154	28,941	59,095	8.00
9.00 00900	HOUSEKEEPING	0	29,111	27,940	57,051	9.00
10.00 01000	DIETARY	0	37,428	35,923	73,351	10.00
11.00 01100	CAFETERIA	0	33,613	32,261	65,874	11.00
13.00 01300	NURSING ADMINISTRATION	0	9,241	8,870	18,111	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	46,947	45,059	92,006	14.00
15.00 01500	PHARMACY	0	27,117	26,027	53,144	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	43,884	42,119	86,003	16.00
17.00 01700	SOCIAL SERVICE	0	11,407	10,948	22,355	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	361,923	347,369	709,292	30.00
31.00 03100	INTENSIVE CARE UNIT	0	45,521	43,690	89,211	31.00
43.00 04300	NURSERY	0	9,888	9,491	19,379	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	171,403	164,511	335,914	50.00
51.00 05100	RECOVERY ROOM	0	13,493	12,950	26,443	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00 05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	144,444	138,636	283,080	54.00
54.01 05401	ULTRASOUND	0	0	0	0	54.01
56.00 05600	RADIOISOTOPE	0	0	0	0	56.00
57.00 05700	CT SCAN	0	0	0	0	57.00
58.00 05800	MRI	0	0	0	0	58.00
60.00 06000	LABORATORY	0	40,544	38,913	79,457	60.00
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	1,558	1,495	3,053	62.00
65.00 06500	RESPIRATORY THERAPY	0	40,966	39,319	80,285	65.00
66.00 06600	PHYSICAL THERAPY	0	116,892	112,191	229,083	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	3,182	3,054	6,236	67.00
68.00 06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00 06900	ELECTROCARDIOLOGY	0	53,667	51,509	105,176	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00 03610	SLEEP LAB	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	35,883	34,440	70,323	90.00
91.00 09100	EMERGENCY	0	97,286	93,374	190,660	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART				0	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500	AMBULANCE SERVICES	0	33,758	32,400	66,158	95.00
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	0	2,319,534	2,226,261	4,545,795	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	10,377	9,960	20,337	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	222,548	213,599	436,147	192.00
200.00	Cross Foot Adjustments				0	200.00
201.00	Negative Cost Centers		0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	0	2,552,459	2,449,820	5,002,279	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-1318

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

Worksheet B
Part II
Date/Time Prepared:
5/31/2023 3:43 pm

Cost Center Description		ADMINISTRATIVE	ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		5.01	5.02	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00570	37,564					5.01
5.02	00590	0	310,783				5.02
7.00	00700		39,420	1,396,110			7.00
8.00	00800		1,366	29,039	89,500		8.00
9.00	00900		6,508	28,035	0	92,162	9.00
10.00	01000		4,078	36,045	0	2,543	10.00
11.00	01100		1,008	32,370	0	2,283	11.00
13.00	01300		4,552	8,900	0	628	13.00
14.00	01400		3,906	45,212	0	3,189	14.00
15.00	01500		7,081	26,115	0	1,842	15.00
16.00	01600		3,944	42,262	0	2,981	16.00
17.00	01700		2,495	10,985	0	775	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	2,419	50,338	348,549	73,361	24,585	30.00
31.00	03100	308	9,208	43,839	10,220	3,092	31.00
43.00	04300	46	5,444	9,523	5,919	672	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	3,205	13,336	165,069	0	11,644	50.00
51.00	05100	668	4,791	12,994	0	917	51.00
52.00	05200	0	0	0	0	0	52.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	7,483	18,352	139,106	0	9,813	54.00
54.01	05401	0	0	0	0	0	54.01
56.00	05600	0	0	0	0	0	56.00
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
60.00	06000	5,178	23,290	39,045	0	2,754	60.00
62.00	06200	98	650	1,500	0	106	62.00
65.00	06500	1,211	11,187	39,452	0	2,783	65.00
66.00	06600	534	6,426	112,572	0	7,941	66.00
67.00	06700	338	2,444	3,064	0	216	67.00
68.00	06800	46	677	0	0	0	68.00
69.00	06900	1,467	4,173	51,683	0	3,646	69.00
71.00	07100	624	286	0	0	0	71.00
72.00	07200	57	490	0	0	0	72.00
73.00	07300	5,268	12,472	0	0	0	73.00
76.00	03610	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	32	2,044	34,557	0	2,438	90.00
91.00	09100	6,203	57,595	93,691	0	6,609	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	2,379	8,684	32,510	0	0	95.00
SPECIAL PURPOSE COST CENTERS							
118.00		37,564	306,245	1,386,117	89,500	91,457	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	202	9,993	0	705	190.00
192.00	19200	0	4,336	0	0	0	192.00
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		37,564	310,783	1,396,110	89,500	92,162	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-1318	Period: From 01/01/2022 To 12/31/2022	Worksheet B Part II Date/Time Prepared: 5/31/2023 3:43 pm
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Cost Center Description		DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		10.00	11.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00570						5.01
5.02	00590						5.02
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000	116,276					10.00
11.00	01100	0	101,606				11.00
13.00	01300	0	2,245	34,970			13.00
14.00	01400	0	2,822	0	147,386		14.00
15.00	01500	0	3,295	0	5,496	97,674	15.00
16.00	01600	0	820	0	18	0	16.00
17.00	01700	0	1,634	0	1	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	103,727	24,683	18,790	17,951	0	30.00
31.00	03100	12,549	2,405	3,538	1,852	0	31.00
43.00	04300	0	1,960	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	3,420	1,720	24,603	0	50.00
51.00	05100	0	1,689	1,626	1,743	0	51.00
52.00	05200	0	0	0	0	0	52.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	0	9,447	150	7,258	0	54.00
54.01	05401	0	0	0	0	0	54.01
56.00	05600	0	0	0	0	0	56.00
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
60.00	06000	0	11,414	1	46,899	0	60.00
62.00	06200	0	0	0	6,570	0	62.00
65.00	06500	0	6,451	0	7,545	0	65.00
66.00	06600	0	0	0	302	0	66.00
67.00	06700	0	0	0	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
69.00	06900	0	1,891	0	638	0	69.00
71.00	07100	0	0	0	1,014	0	71.00
72.00	07200	0	0	0	5,432	0	72.00
73.00	07300	0	0	0	0	97,674	73.00
76.00	03610	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	799	667	482	0	90.00
91.00	09100	0	9,753	8,476	10,450	0	91.00
92.00	09200	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	0	16,878	2	9,132	0	95.00
SPECIAL PURPOSE COST CENTERS							
118.00		116,276	101,606	34,970	147,386	97,674	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	0	0	0	0	192.00
200.00		0	0	0	0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		116,276	101,606	34,970	147,386	97,674	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-1318

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

Worksheet B
Part II
Date/Time Prepared:
5/31/2023 3:43 pm

Cost Center Description		MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		16.00	17.00	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
5.01	00570	ADMITTING					5.01
5.02	00590	ADMINISTRATIVE AND GENERAL					5.02
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	136,102				16.00
17.00	01700	SOCIAL SERVICE	0	38,504			17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	8,769	31,560	1,418,322	0	1,418,322
31.00	03100	INTENSIVE CARE UNIT	1,115	4,397	182,484	0	182,484
43.00	04300	NURSERY	166	2,547	46,163	0	46,163
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	11,620	0	571,155	0	571,155
51.00	05100	RECOVERY ROOM	2,422	0	53,647	0	53,647
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	27,048	0	503,091	0	503,091
54.01	05401	ULTRASOUND	0	0	0	0	54.01
56.00	05600	RADIOLOGY	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	58.00
60.00	06000	LABORATORY	18,772	0	228,198	0	228,198
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	356	0	12,333	0	12,333
65.00	06500	RESPIRATORY THERAPY	4,391	0	154,407	0	154,407
66.00	06600	PHYSICAL THERAPY	1,935	0	358,793	0	358,793
67.00	06700	OCCUPATIONAL THERAPY	1,225	0	13,523	0	13,523
68.00	06800	SPEECH PATHOLOGY	165	0	888	0	888
69.00	06900	ELECTROCARDIOLOGY	5,318	0	174,288	0	174,288
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,264	0	4,188	0	4,188
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	207	0	6,186	0	6,186
73.00	07300	DRUGS CHARGED TO PATIENTS	19,101	0	134,515	0	134,515
76.00	03610	SLEEP LAB	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	115	0	111,611	0	111,611
91.00	09100	EMERGENCY	22,489	0	411,814	0	411,814
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	8,624	0	144,953	0	144,953
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	136,102	38,504	4,530,559	0	4,530,559
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	31,237	0	31,237
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	440,483	0	440,483
200.00		Cross Foot Adjustments			0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	136,102	38,504	5,002,279	0	5,002,279

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-1318

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

Worksheet B-1
Date/Time Prepared:
5/31/2023 3:43 pm

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	ADMITTING (GROSS CHARGES)	Reconciliation	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
	1.00	2.00				
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	193,337				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		193,337			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	882	882	15,835,753		4.00
5.01 00570	ADMITTING	1,421	1,421	553,544	184,992,044	5.01
5.02 00590	ADMINISTRATIVE AND GENERAL	11,954	11,954	1,036,337	0	-8,139,903
7.00 00700	OPERATION OF PLANT	52,416	52,416	354,948	0	0
8.00 00800	LAUNDRY & LINEN SERVICE	2,284	2,284	0	0	0
9.00 00900	HOUSEKEEPING	2,205	2,205	394,037	0	0
10.00 01000	DIETARY	2,835	2,835	180,033	0	0
11.00 01100	CAFETERIA	2,546	2,546	49,301	0	0
13.00 01300	NURSING ADMINISTRATION	700	700	370,434	0	0
14.00 01400	CENTRAL SERVICES & SUPPLY	3,556	3,556	174,043	0	0
15.00 01500	PHARMACY	2,054	2,054	486,321	0	0
16.00 01600	MEDICAL RECORDS & LIBRARY	3,324	3,324	51,615	0	0
17.00 01700	SOCIAL SERVICE	864	864	179,587	0	0
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	27,414	27,414	2,982,655	11,914,756	0
31.00 03100	INTENSIVE CARE UNIT	3,448	3,448	520,448	1,515,111	0
43.00 04300	NURSERY	749	749	351,526	225,333	0
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	12,983	12,983	432,844	15,788,163	0
51.00 05100	RECOVERY ROOM	1,022	1,022	245,744	3,291,138	0
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0
53.00 05300	ANESTHESIOLOGY	0	0	0	0	0
54.00 05400	RADIOLOGY-DIAGNOSTIC	10,941	10,941	939,361	36,819,538	0
54.01 05401	ULTRASOUND	0	0	0	0	0
56.00 05600	RADIOISOTOPE	0	0	0	0	0
57.00 05700	CT SCAN	0	0	0	0	0
58.00 05800	MRI	0	0	0	0	0
60.00 06000	LABORATORY	3,071	3,071	963,156	25,505,307	0
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELL	118	118	0	483,295	0
65.00 06500	RESPIRATORY THERAPY	3,103	3,103	764,567	5,966,661	0
66.00 06600	PHYSICAL THERAPY	8,854	8,854	0	2,628,622	0
67.00 06700	OCCUPATIONAL THERAPY	241	241	0	1,664,469	0
68.00 06800	SPEECH PATHOLOGY	0	0	0	224,358	0
69.00 06900	ELECTROCARDIOLOGY	4,065	4,065	205,738	7,225,755	0
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	3,075,776	0
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	281,654	0
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	25,951,999	0
76.00 03610	SLEEP LAB	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	2,718	2,718	106,687	156,065	0
91.00 09100	EMERGENCY	7,369	7,369	4,086,083	30,556,016	0
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART					0
OTHER REIMBURSABLE COST CENTERS						
95.00 09500	AMBULANCE SERVICES	2,557	2,557	406,744	11,718,028	0
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	175,694	175,694	15,835,753	184,992,044	-8,139,903
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	786	786	0	0	0
192.00 19200	PHYSICIANS' PRIVATE OFFICES	16,857	16,857	0	0	0
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers					201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	2,552,459	2,449,820	2,221,971	1,503,132	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	13.202124	12.671242	0.140314	0.008125	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			22,820	37,564	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.001441	0.000203	205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)					206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)					207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-1318

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

Worksheet B-1

Date/Time Prepared:
5/31/2023 3:43 pm

Cost Center Description		ADMINISTRATIVE AND GENERAL (ACCUMULATED COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (TOTAL PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	
		5.02	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
5.01	00570	ADMITTING					5.01
5.02	00590	ADMINISTRATIVE AND GENERAL	31,262,371				5.02
7.00	00700	OPERATION OF PLANT	3,965,363	109,807			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	137,457	2,284	3,538		8.00
9.00	00900	HOUSEKEEPING	654,705	2,205	0	102,761	9.00
10.00	01000	DIETARY	410,187	2,835	0	2,835	3,799
11.00	01100	CAFETERIA	101,396	2,546	0	2,546	0
13.00	01300	NURSING ADMINISTRATION	457,852	700	0	700	0
14.00	01400	CENTRAL SERVICES & SUPPLY	392,873	3,556	0	3,556	0
15.00	01500	PHARMACY	712,325	2,054	0	2,054	0
16.00	01600	MEDICAL RECORDS & LIBRARY	396,708	3,324	0	3,324	0
17.00	01700	SOCIAL SERVICE	251,028	864	0	864	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	5,063,681	27,414	2,900	27,414	3,389
31.00	03100	INTENSIVE CARE UNIT	926,237	3,448	404	3,448	410
43.00	04300	NURSERY	547,671	749	234	749	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,341,516	12,983	0	12,983	0
51.00	05100	RECOVERY ROOM	481,922	1,022	0	1,022	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,846,125	10,941	0	10,941	0
54.01	05401	ULTRASOUND	0	0	0	0	0
56.00	05600	RADIOISOTOPE	0	0	0	0	0
57.00	05700	CT SCAN	0	0	0	0	0
58.00	05800	MRI	0	0	0	0	0
60.00	06000	LABORATORY	2,342,792	3,071	0	3,071	0
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	65,407	118	0	118	0
65.00	06500	RESPIRATORY THERAPY	1,125,331	3,103	0	3,103	0
66.00	06600	PHYSICAL THERAPY	646,441	8,854	0	8,854	0
67.00	06700	OCCUPATIONAL THERAPY	245,889	241	0	241	0
68.00	06800	SPEECH PATHOLOGY	68,095	0	0	0	0
69.00	06900	ELECTROCARDIOLOGY	419,746	4,065	0	4,065	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	28,731	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	49,328	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	1,254,596	0	0	0	0
76.00	03610	SLEEP LAB	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	205,637	2,718	0	2,718	0
91.00	09100	EMERGENCY	5,793,320	7,369	0	7,369	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	873,528	2,557	0	0	0
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	30,805,887	109,021	3,538	101,975	3,799
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	20,337	786	0	786	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	436,147	0	0	0	0
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	8,139,903	4,997,840	277,203	925,533	671,557
203.00		Unit cost multiplier (Wkst. B, Part I)	0.260374	45.514767	78.350198	9.006656	176.772045
204.00		Cost to be allocated (per Wkst. B, Part II)	310,783	1,396,110	89,500	92,162	116,276
205.00		Unit cost multiplier (Wkst. B, Part II)	0.009941	12.714217	25.296778	0.896858	30.607002
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)					206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)					207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-1318

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

Worksheet B-1

Date/Time Prepared:
5/31/2023 3:43 pm

Cost Center Description		CAFETERIA (FTES)	NURSING ADMINISTRATION (NURSING SALARIES)	CENTRAL SERVICES & SUPPLY (COSTED REQ)	PHARMACY (COSTED REQ)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
		11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00570						5.01
5.02	00590						5.02
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	14,617					11.00
13.00	01300	323	5,540,540				13.00
14.00	01400	406	0	1,310,726			14.00
15.00	01500	474	0	48,880	1,043,736		15.00
16.00	01600	118	0	164	0	184,992,044	16.00
17.00	01700	235	0	7	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	3,551	2,977,234	159,641	0	11,914,756	30.00
31.00	03100	346	560,466	16,470	0	1,515,111	31.00
43.00	04300	282	0	0	0	225,333	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	492	272,511	218,794	0	15,788,163	50.00
51.00	05100	243	257,562	15,499	0	3,291,138	51.00
52.00	05200	0	0	0	0	0	52.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	1,359	23,711	64,550	0	36,819,538	54.00
54.01	05401	0	0	0	0	0	54.01
56.00	05600	0	0	0	0	0	56.00
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
60.00	06000	1,642	132	417,076	0	25,505,307	60.00
62.00	06200	0	0	58,427	0	483,295	62.00
65.00	06500	928	72	67,096	0	5,966,661	65.00
66.00	06600	0	0	2,687	0	2,628,622	66.00
67.00	06700	0	0	0	0	1,664,469	67.00
68.00	06800	0	0	0	0	224,358	68.00
69.00	06900	272	0	5,675	0	7,225,755	69.00
71.00	07100	0	0	9,016	0	3,075,776	71.00
72.00	07200	0	0	48,307	0	281,654	72.00
73.00	07300	0	0	0	1,043,736	25,951,999	73.00
76.00	03610	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	115	105,674	4,285	0	156,065	90.00
91.00	09100	1,403	1,342,795	92,937	0	30,556,016	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	2,428	383	81,215	0	11,718,028	95.00
SPECIAL PURPOSE COST CENTERS							
118.00							
		14,617	5,540,540	1,310,726	1,043,736	184,992,044	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	0	0	0	0	192.00
200.00							200.00
201.00							201.00
202.00		266,609	621,121	696,451	1,044,401	683,468	202.00
203.00		18.239652	0.112105	0.531348	1.000637	0.003695	203.00
204.00		101,606	34,970	147,386	97,674	136,102	204.00
205.00		6.951221	0.006312	0.112446	0.093581	0.000736	205.00
206.00							206.00
207.00							207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-1318

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

Worksheet B-1

Date/Time Prepared:
5/31/2023 3:43 pm

Cost Center Description		SOCIAL SERVICE	
		(TOTAL PATIENT DAYS)	
		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
5.01	00570	ADMITTING	5.01
5.02	00590	ADMINISTRATIVE AND GENERAL	5.02
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
13.00	01300	NURSING ADMINISTRATION	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14.00
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
		3,538	
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
		2,900	
		404	
		234	
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
51.00	05100	RECOVERY ROOM	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	52.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
54.01	05401	ULTRASOUND	54.01
56.00	05600	RADIOISOTOPE	56.00
57.00	05700	CT SCAN	57.00
58.00	05800	MRI	58.00
60.00	06000	LABORATORY	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	62.00
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
67.00	06700	OCCUPATIONAL THERAPY	67.00
68.00	06800	SPEECH PATHOLOGY	68.00
69.00	06900	ELECTROCARDIOLOGY	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
76.00	03610	SLEEP LAB	76.00
OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	90.00
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	92.00
OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	95.00
SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
		3,538	
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	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
		367,786	
		103.953081	
		38,504	
		10.882985	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-1318

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

Worksheet C
Part I
Date/Time Prepared:
5/31/2023 3:43 pm

Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
				Total Costs	Hospital		
					RCE Disallowance	Total Costs	
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	9,531,920		9,531,920	0	0	30.00
31.00	03100 INTENSIVE CARE UNIT	1,585,013		1,585,013	0	0	31.00
43.00	04300 NURSERY	779,743		779,743	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	2,612,780		2,612,780	0	0	50.00
51.00	05100 RECOVERY ROOM	716,825		716,825	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0		0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	3,121,042		3,121,042	0	0	54.00
54.01	05401 ULTRASOUND	0		0	0	0	54.01
56.00	05600 RADIOISOTOPE	0		0	0	0	56.00
57.00	05700 CT SCAN	0		0	0	0	57.00
58.00	05800 MRI	0		0	0	0	58.00
60.00	06000 LABORATORY	3,466,048		3,466,048	0	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	121,702		121,702	0	0	62.00
65.00	06500 RESPIRATORY THERAPY	1,662,150	0	1,662,150	0	0	65.00
66.00	06600 PHYSICAL THERAPY	1,308,631	0	1,308,631	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	329,202	0	329,202	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	86,654	0	86,654	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	785,342		785,342	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	52,368		52,368	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	88,881		88,881	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	2,721,554		2,721,554	0	0	73.00
76.00	03610 SLEEP LAB	0		0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	424,168		424,168	0	0	90.00
91.00	09100 EMERGENCY	8,041,924		8,041,924	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1,095,979		1,095,979	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES	1,348,133		1,348,133	0	0	95.00
200.00	Subtotal (see instructions)	39,880,059	0	39,880,059	0	0	200.00
201.00	Less Observation Beds	1,095,979		1,095,979	0	0	201.00
202.00	Total (see instructions)	38,784,080	0	38,784,080	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-1318

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

Worksheet C
Part I
Date/Time Prepared:
5/31/2023 3:43 pm

		Title XVIII			Hospital	Cost		
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
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	10,194,859		10,194,859			30.00
31.00	03100	INTENSIVE CARE UNIT	1,515,111		1,515,111			31.00
43.00	04300	NURSERY	225,333		225,333			43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	3,099,079	12,689,084	15,788,163	0.165490	0.000000	50.00
51.00	05100	RECOVERY ROOM	562,882	2,728,256	3,291,138	0.217805	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,093,502	30,726,036	36,819,538	0.084766	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	0.000000	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0.000000	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	05800	MRI	0	0	0	0.000000	0.000000	58.00
60.00	06000	LABORATORY	6,747,383	18,757,924	25,505,307	0.135895	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	262,431	220,864	483,295	0.251817	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	5,087,885	878,776	5,966,661	0.278573	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,211,414	1,417,208	2,628,622	0.497839	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,210,890	453,579	1,664,469	0.197782	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	109,193	115,165	224,358	0.386231	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	1,733,526	5,492,229	7,225,755	0.108686	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,830,462	1,245,314	3,075,776	0.017026	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	33,177	248,477	281,654	0.315568	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	14,098,891	11,853,108	25,951,999	0.104869	0.000000	73.00
76.00	03610	SLEEP LAB	0	0	0	0.000000	0.000000	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	31,757	124,308	156,065	2.717893	0.000000	90.00
91.00	09100	EMERGENCY	3,708,515	26,847,501	30,556,016	0.263186	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	616,349	1,103,548	1,719,897	0.637235	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	11,718,028	11,718,028	0.115048	0.000000	95.00
200.00		Subtotal (see instructions)	58,372,639	126,619,405	184,992,044			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	58,372,639	126,619,405	184,992,044			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-1318	Period: From 01/01/2022 To 12/31/2022	Worksheet C Part I Date/Time Prepared: 5/31/2023 3:43 pm
		Title XVIII	Hospital	Cost

Cost Center Description		PPS Inpatient Ratio		
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
43.00	04300 NURSERY			43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.000000		50.00
51.00	05100 RECOVERY ROOM	0.000000		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300 ANESTHESIOLOGY	0.000000		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000		54.00
54.01	05401 ULTRASOUND	0.000000		54.01
56.00	05600 RADIOISOTOPE	0.000000		56.00
57.00	05700 CT SCAN	0.000000		57.00
58.00	05800 MRI	0.000000		58.00
60.00	06000 LABORATORY	0.000000		60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000		62.00
65.00	06500 RESPIRATORY THERAPY	0.000000		65.00
66.00	06600 PHYSICAL THERAPY	0.000000		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800 SPEECH PATHOLOGY	0.000000		68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03610 SLEEP LAB	0.000000		76.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0.000000		90.00
91.00	09100 EMERGENCY	0.000000		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
OTHER REIMBURSABLE COST CENTERS				
95.00	09500 AMBULANCE SERVICES	0.000000		95.00
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: 15-1318

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

Worksheet C
Part I
Date/Time Prepared:
5/31/2023 3:43 pm

		Title XIX		Hospital		PPS
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
			Total Costs	RCE Disallowance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS		9,531,920	0	9,531,920	30.00
31.00	03100 INTENSIVE CARE UNIT		1,585,013	0	1,585,013	31.00
43.00	04300 NURSERY		779,743	0	779,743	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM		2,612,780	0	2,612,780	50.00
51.00	05100 RECOVERY ROOM		716,825	0	716,825	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM		0	0	0	52.00
53.00	05300 ANESTHESIOLOGY		0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC		3,121,042	0	3,121,042	54.00
54.01	05401 ULTRASOUND		0	0	0	54.01
56.00	05600 RADIOISOTOPE		0	0	0	56.00
57.00	05700 CT SCAN		0	0	0	57.00
58.00	05800 MRI		0	0	0	58.00
60.00	06000 LABORATORY		3,466,048	0	3,466,048	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL		121,702	0	121,702	62.00
65.00	06500 RESPIRATORY THERAPY	0	1,662,150	0	1,662,150	65.00
66.00	06600 PHYSICAL THERAPY	0	1,308,631	0	1,308,631	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	329,202	0	329,202	67.00
68.00	06800 SPEECH PATHOLOGY	0	86,654	0	86,654	68.00
69.00	06900 ELECTROCARDIOLOGY		785,342	0	785,342	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		52,368	0	52,368	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		88,881	0	88,881	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS		2,721,554	0	2,721,554	73.00
76.00	03610 SLEEP LAB		0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC		424,168	0	424,168	90.00
91.00	09100 EMERGENCY		8,041,924	0	8,041,924	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART		1,095,979	0	1,095,979	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES		1,348,133	0	1,348,133	95.00
200.00	Subtotal (see instructions)	0	39,880,059	0	39,880,059	200.00
201.00	Less Observation Beds		1,095,979	0	1,095,979	201.00
202.00	Total (see instructions)	0	38,784,080	0	38,784,080	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-1318

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

Worksheet C
Part I
Date/Time Prepared:
5/31/2023 3:43 pm

		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
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	10,194,859		10,194,859			30.00
31.00	03100	INTENSIVE CARE UNIT	1,515,111		1,515,111			31.00
43.00	04300	NURSERY	225,333		225,333			43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	3,099,079	12,689,084	15,788,163	0.165490	0.000000	50.00
51.00	05100	RECOVERY ROOM	562,882	2,728,256	3,291,138	0.217805	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,093,502	30,726,036	36,819,538	0.084766	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	0.000000	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0.000000	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	05800	MRI	0	0	0	0.000000	0.000000	58.00
60.00	06000	LABORATORY	6,747,383	18,757,924	25,505,307	0.135895	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	262,431	220,864	483,295	0.251817	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	5,087,885	878,776	5,966,661	0.278573	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,211,414	1,417,208	2,628,622	0.497839	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,210,890	453,579	1,664,469	0.197782	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	109,193	115,165	224,358	0.386231	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	1,733,526	5,492,229	7,225,755	0.108686	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,830,462	1,245,314	3,075,776	0.017026	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	33,177	248,477	281,654	0.315568	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	14,098,891	11,853,108	25,951,999	0.104869	0.000000	73.00
76.00	03610	SLEEP LAB	0	0	0	0.000000	0.000000	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	31,757	124,308	156,065	2.717893	0.000000	90.00
91.00	09100	EMERGENCY	3,708,515	26,847,501	30,556,016	0.263186	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	616,349	1,103,548	1,719,897	0.637235	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	11,718,028	11,718,028	0.115048	0.000000	95.00
200.00		Subtotal (see instructions)	58,372,639	126,619,405	184,992,044			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	58,372,639	126,619,405	184,992,044			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-1318	Period: From 01/01/2022 To 12/31/2022	Worksheet C Part I Date/Time Prepared: 5/31/2023 3:43 pm
		Title XIX	Hospital	PPS

Cost Center Description		PPS Inpatient Ratio		
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
43.00	04300 NURSERY			43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.165490		50.00
51.00	05100 RECOVERY ROOM	0.217805		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300 ANESTHESIOLOGY	0.000000		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.084766		54.00
54.01	05401 ULTRASOUND	0.000000		54.01
56.00	05600 RADIOISOTOPE	0.000000		56.00
57.00	05700 CT SCAN	0.000000		57.00
58.00	05800 MRI	0.000000		58.00
60.00	06000 LABORATORY	0.135895		60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0.251817		62.00
65.00	06500 RESPIRATORY THERAPY	0.278573		65.00
66.00	06600 PHYSICAL THERAPY	0.497839		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.197782		67.00
68.00	06800 SPEECH PATHOLOGY	0.386231		68.00
69.00	06900 ELECTROCARDIOLOGY	0.108686		69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.017026		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.315568		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.104869		73.00
76.00	03610 SLEEP LAB	0.000000		76.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	2.717893		90.00
91.00	09100 EMERGENCY	0.263186		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.637235		92.00
OTHER REIMBURSABLE COST CENTERS				
95.00	09500 AMBULANCE SERVICES	0.115048		95.00
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: 15-1318

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

Worksheet C Part II Date/Time Prepared: 5/31/2023 3:43 pm

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	2,612,780	571,155	2,041,625	0	0	50.00
51.00	05100	RECOVERY ROOM	716,825	53,647	663,178	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,121,042	503,091	2,617,951	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	3,466,048	228,198	3,237,850	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	121,702	12,333	109,369	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	1,662,150	154,407	1,507,743	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,308,631	358,793	949,838	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	329,202	13,523	315,679	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	86,654	888	85,766	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	785,342	174,288	611,054	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	52,368	4,188	48,180	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	88,881	6,186	82,695	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,721,554	134,515	2,587,039	0	0	73.00
76.00	03610	SLEEP LAB	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	424,168	111,611	312,557	0	0	90.00
91.00	09100	EMERGENCY	8,041,924	411,814	7,630,110	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,095,979	163,078	932,901	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	1,348,133	144,953	1,203,180	0	0	95.00
200.00		Subtotal (sum of lines 50 thru 199)	27,983,383	3,046,668	24,936,715	0	0	200.00
201.00		Less Observation Beds	1,095,979	163,078	932,901	0	0	201.00
202.00		Total (line 200 minus line 201)	26,887,404	2,883,590	24,003,814	0	0	202.00

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

Provider CCN: 15-1318

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

Worksheet C Part II Date/Time Prepared: 5/31/2023 3:43 pm

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)	Hospital	PPS
		6.00	7.00	8.00		
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	2,612,780	15,788,163	0.165490		50.00
51.00	05100 RECOVERY ROOM	716,825	3,291,138	0.217805		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0.000000		52.00
53.00	05300 ANESTHESIOLOGY	0	0	0.000000		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	3,121,042	36,819,538	0.084766		54.00
54.01	05401 ULTRASOUND	0	0	0.000000		54.01
56.00	05600 RADIOISOTOPE	0	0	0.000000		56.00
57.00	05700 CT SCAN	0	0	0.000000		57.00
58.00	05800 MRI	0	0	0.000000		58.00
60.00	06000 LABORATORY	3,466,048	25,505,307	0.135895		60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	121,702	483,295	0.251817		62.00
65.00	06500 RESPIRATORY THERAPY	1,662,150	5,966,661	0.278573		65.00
66.00	06600 PHYSICAL THERAPY	1,308,631	2,628,622	0.497839		66.00
67.00	06700 OCCUPATIONAL THERAPY	329,202	1,664,469	0.197782		67.00
68.00	06800 SPEECH PATHOLOGY	86,654	224,358	0.386231		68.00
69.00	06900 ELECTROCARDIOLOGY	785,342	7,225,755	0.108686		69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	52,368	3,075,776	0.017026		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	88,881	281,654	0.315568		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	2,721,554	25,951,999	0.104869		73.00
76.00	03610 SLEEP LAB	0	0	0.000000		76.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	424,168	156,065	2.717893		90.00
91.00	09100 EMERGENCY	8,041,924	30,556,016	0.263186		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1,095,979	1,719,897	0.637235		92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	1,348,133	11,718,028	0.115048		95.00
200.00	Subtotal (sum of lines 50 thru 199)	27,983,383	173,056,741			200.00
201.00	Less Observation Beds	1,095,979	0			201.00
202.00	Total (line 200 minus line 201)	26,887,404	173,056,741			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 15-1318

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

Worksheet D
Part II
Date/Time Prepared:
5/31/2023 3:43 pm

Cost Center Description		Title XVIII			Hospital	Cost		
		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	571,155	15,788,163	0.036176	363,864	13,163	50.00
51.00	05100	RECOVERY ROOM	53,647	3,291,138	0.016300	64,698	1,055	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	503,091	36,819,538	0.013664	1,857,125	25,376	54.00
54.01	05401	ULTRASOUND	0	0	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000	0	0	56.00
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800	MRI	0	0	0.000000	0	0	58.00
60.00	06000	LABORATORY	228,198	25,505,307	0.008947	2,059,239	18,424	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	12,333	483,295	0.025519	93,943	2,397	62.00
65.00	06500	RESPIRATORY THERAPY	154,407	5,966,661	0.025878	1,466,210	37,943	65.00
66.00	06600	PHYSICAL THERAPY	358,793	2,628,622	0.136495	256,263	34,979	66.00
67.00	06700	OCCUPATIONAL THERAPY	13,523	1,664,469	0.008125	270,471	2,198	67.00
68.00	06800	SPEECH PATHOLOGY	888	224,358	0.003958	27,348	108	68.00
69.00	06900	ELECTROCARDIOLOGY	174,288	7,225,755	0.024120	653,901	15,772	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,188	3,075,776	0.001362	539,962	735	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,186	281,654	0.021963	6,781	149	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	134,515	25,951,999	0.005183	4,377,337	22,688	73.00
76.00	03610	SLEEP LAB	0	0	0.000000	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	111,611	156,065	0.715157	180	129	90.00
91.00	09100	EMERGENCY	411,814	30,556,016	0.013477	17,909	241	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	163,078	1,719,897	0.094818	3,540	336	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	2,901,715	161,338,713		12,058,771	175,693	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1318

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

Worksheet D
Part IV
Date/Time Prepared:
5/31/2023 3:43 pm

Cost Center Description			Title XVIII					Allied Health
			Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03610	SLEEP LAB	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
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
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-1318	Period: From 01/01/2022 To 12/31/2022	Worksheet D Part IV Date/Time Prepared: 5/31/2023 3:43 pm
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Cost Center Description			Title XVIII				Hospital	
			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)	Cost
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	15,788,163	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	3,291,138	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	36,819,538	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0	0.000000	57.00
58.00	05800	MRI	0	0	0	0	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	25,505,307	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	483,295	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	5,966,661	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,628,622	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,664,469	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	224,358	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	7,225,755	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	3,075,776	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	281,654	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	25,951,999	0.000000	73.00
76.00	03610	SLEEP LAB	0	0	0	0	0.000000	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	156,065	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	30,556,016	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	1,719,897	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0.000000	95.00
200.00		Total (lines 50 through 199)	0	0	0	161,338,713		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1318

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

Worksheet D
Part IV
Date/Time Prepared:
5/31/2023 3:43 pm

Cost Center Description		Title XVIII			Hospital		Cost
		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	363,864	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0.000000	64,698	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	1,857,125	0	0	0	54.00
54.01	05401 ULTRASOUND	0.000000	0	0	0	0	54.01
56.00	05600 RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700 CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800 MRI	0.000000	0	0	0	0	58.00
60.00	06000 LABORATORY	0.000000	2,059,239	0	0	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	93,943	0	0	0	62.00
65.00	06500 RESPIRATORY THERAPY	0.000000	1,466,210	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.000000	256,263	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	270,471	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	27,348	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	653,901	0	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	539,962	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	6,781	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	4,377,337	0	0	0	73.00
76.00	03610 SLEEP LAB	0.000000	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0.000000	180	0	0	0	90.00
91.00	09100 EMERGENCY	0.000000	17,909	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000	3,540	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50 through 199)		12,058,771	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-1318

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

Worksheet D
Part V
Date/Time Prepared:
5/31/2023 3:43 pm

		Title XVIII		Hospital		Cost	
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	0.165490	0	2,553,074	0	0	50.00
51.00	05100 RECOVERY ROOM	0.217805	0	621,491	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.084766	0	7,713,610	0	0	54.00
54.01	05401 ULTRASOUND	0.000000	0	0	0	0	54.01
56.00	05600 RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700 CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800 MRI	0.000000	0	0	0	0	58.00
60.00	06000 LABORATORY	0.135895	0	4,005,034	0	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0.251817	0	43,834	0	0	62.00
65.00	06500 RESPIRATORY THERAPY	0.278573	0	250,062	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.497839	0	272,990	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.197782	0	27,291	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.386231	0	14,056	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.108686	0	1,478,215	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.017026	0	143,179	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.315568	0	34,522	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.104869	0	4,216,218	791	0	73.00
76.00	03610 SLEEP LAB	0.000000	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	2.717893	0	13,030	10,348	0	90.00
91.00	09100 EMERGENCY	0.263186	0	5,495,344	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.637235	0	393,599	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES	0.115048	0	0	0	0	95.00
200.00	Subtotal (see instructions)		0	27,275,549	11,139	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00	Net Charges (line 200 - line 201)		0	27,275,549	11,139	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-1318	Period: From 01/01/2022 To 12/31/2022	Worksheet D Part V Date/Time Prepared: 5/31/2023 3:43 pm
	Title XVIII	Hospital	Cost

Cost Center Description	Costs		Hospital	Cost
	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	422,508	0	50.00
51.00	05100 RECOVERY ROOM	135,364	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	653,852	0	54.00
54.01	05401 ULTRASOUND	0	0	54.01
56.00	05600 RADIOISOTOPE	0	0	56.00
57.00	05700 CT SCAN	0	0	57.00
58.00	05800 MRI	0	0	58.00
60.00	06000 LABORATORY	544,264	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	11,038	0	62.00
65.00	06500 RESPIRATORY THERAPY	69,661	0	65.00
66.00	06600 PHYSICAL THERAPY	135,905	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	5,398	0	67.00
68.00	06800 SPEECH PATHOLOGY	5,429	0	68.00
69.00	06900 ELECTROCARDIOLOGY	160,661	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	2,438	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	10,894	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	442,151	83	73.00
76.00	03610 SLEEP LAB	0	0	76.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	35,414	28,125	90.00
91.00	09100 EMERGENCY	1,446,298	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	250,815	0	92.00
OTHER REIMBURSABLE COST CENTERS				
95.00	09500 AMBULANCE SERVICES	0		95.00
200.00	Subtotal (see instructions)	4,332,090	28,208	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00	Net Charges (line 200 - line 201)	4,332,090	28,208	202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 15-1318	Period: From 01/01/2022 To 12/31/2022	Worksheet D Part I Date/Time Prepared: 5/31/2023 3:43 pm
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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	1,418,322	422,626	995,696	3,468	287.11	30.00
31.00	INTENSIVE CARE UNIT	182,484		182,484	404	451.69	31.00
43.00	NURSERY	46,163		46,163	234	197.28	43.00
200.00	Total (Lines 30 through 199)	1,646,969		1,224,343	4,106		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	51	14,643				
31.00	INTENSIVE CARE UNIT	2	903				
43.00	NURSERY	21	4,143				
200.00	Total (Lines 30 through 199)	74	19,689				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 15-1318

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

Worksheet D
Part II
Date/Time Prepared:
5/31/2023 3:43 pm

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	571,155	15,788,163	0.036176	168,596	6,099	50.00
51.00	05100	RECOVERY ROOM	53,647	3,291,138	0.016300	31,649	516	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	503,091	36,819,538	0.013664	166,979	2,282	54.00
54.01	05401	ULTRASOUND	0	0	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000	0	0	56.00
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800	MRI	0	0	0.000000	0	0	58.00
60.00	06000	LABORATORY	228,198	25,505,307	0.008947	168,682	1,509	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	12,333	483,295	0.025519	10,349	264	62.00
65.00	06500	RESPIRATORY THERAPY	154,407	5,966,661	0.025878	90,908	2,353	65.00
66.00	06600	PHYSICAL THERAPY	358,793	2,628,622	0.136495	5,146	702	66.00
67.00	06700	OCCUPATIONAL THERAPY	13,523	1,664,469	0.008125	5,012	41	67.00
68.00	06800	SPEECH PATHOLOGY	888	224,358	0.003958	4,247	17	68.00
69.00	06900	ELECTROCARDIOLOGY	174,288	7,225,755	0.024120	26,300	634	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,188	3,075,776	0.001362	37,401	51	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,186	281,654	0.021963	972	21	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	134,515	25,951,999	0.005183	389,668	2,020	73.00
76.00	03610	SLEEP LAB	0	0	0.000000	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	111,611	156,065	0.715157	2,295	1,641	90.00
91.00	09100	EMERGENCY	411,814	30,556,016	0.013477	87,586	1,180	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	163,078	1,719,897	0.094818	11,623	1,102	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	2,901,715	161,338,713		1,207,413	20,432	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-1318	Period: From 01/01/2022 To 12/31/2022	Worksheet D Part III Date/Time Prepared: 5/31/2023 3:43 pm
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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	30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	31.00	
43.00	04300	NURSERY	0	0	0	0	43.00	
200.00		Total (lines 30 through 199)	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	3,468	0.00	51 30.00	
31.00	03100	INTENSIVE CARE UNIT		0	404	0.00	2 31.00	
43.00	04300	NURSERY		0	234	0.00	21 43.00	
200.00		Total (lines 30 through 199)		0	4,106		74 200.00	
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: 15-1318

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

Worksheet D
Part IV
Date/Time Prepared:
5/31/2023 3:43 pm

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	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	73.00
76.00	03610	SLEEP LAB	0	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	0	95.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1318

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

Worksheet D
Part IV
Date/Time Prepared:
5/31/2023 3:43 pm

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	15,788,163	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	3,291,138	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	36,819,538	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0	0.000000	57.00
58.00	05800	MRI	0	0	0	0	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	25,505,307	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	483,295	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	5,966,661	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,628,622	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,664,469	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	224,358	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	7,225,755	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	3,075,776	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	281,654	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	25,951,999	0.000000	73.00
76.00	03610	SLEEP LAB	0	0	0	0	0.000000	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	156,065	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	30,556,016	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	1,719,897	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0.000000	95.00
200.00		Total (lines 50 through 199)	0	0	0	161,338,713		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1318

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

Worksheet D
Part IV
Date/Time Prepared:
5/31/2023 3:43 pm

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)	
		9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0.000000	168,596	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0.000000	31,649	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	166,979	0	0	0	54.00
54.01	05401 ULTRASOUND	0.000000	0	0	0	0	54.01
56.00	05600 RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700 CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800 MRI	0.000000	0	0	0	0	58.00
60.00	06000 LABORATORY	0.000000	168,682	0	0	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	10,349	0	0	0	62.00
65.00	06500 RESPIRATORY THERAPY	0.000000	90,908	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.000000	5,146	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	5,012	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	4,247	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	26,300	0	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	37,401	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	972	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	389,668	0	0	0	73.00
76.00	03610 SLEEP LAB	0.000000	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0.000000	2,295	0	0	0	90.00
91.00	09100 EMERGENCY	0.000000	87,586	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000	11,623	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50 through 199)		1,207,413	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-1318

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

Worksheet D
Part V
Date/Time Prepared:
5/31/2023 3:43 pm

		Title XIX		Hospital		PPS	
Cost Center Description		Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs		
			PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0.165490	0	68,747	0	0	50.00
51.00	05100 RECOVERY ROOM	0.217805	0	14,466	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.084766	0	425,280	0	0	54.00
54.01	05401 ULTRASOUND	0.000000	0	0	0	0	54.01
56.00	05600 RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700 CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800 MRI	0.000000	0	0	0	0	58.00
60.00	06000 LABORATORY	0.135895	0	360,435	0	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0.251817	0	3,247	0	0	62.00
65.00	06500 RESPIRATORY THERAPY	0.278573	0	7,666	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.497839	0	2,176	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.197782	0	1,282	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.386231	0	672	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.108686	0	47,808	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.017026	0	6,509	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.315568	0	4,131	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.104869	0	98,914	0	0	73.00
76.00	03610 SLEEP LAB	0.000000	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	2.717893	0	3,068	0	0	90.00
91.00	09100 EMERGENCY	0.263186	0	676,290	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.637235	0	6,230	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES	0.115048	0	257,479			95.00
200.00	Subtotal (see instructions)		0	1,984,400	0	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00	Net Charges (line 200 - line 201)		0	1,984,400	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 15-1318	Period: From 01/01/2022 To 12/31/2022	Worksheet D Part V Date/Time Prepared: 5/31/2023 3:43 pm
		Title XIX	Hospital	PPS

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	11,377	0	50.00
51.00	05100 RECOVERY ROOM	3,151	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	36,049	0	54.00
54.01	05401 ULTRASOUND	0	0	54.01
56.00	05600 RADIOISOTOPE	0	0	56.00
57.00	05700 CT SCAN	0	0	57.00
58.00	05800 MRI	0	0	58.00
60.00	06000 LABORATORY	48,981	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	818	0	62.00
65.00	06500 RESPIRATORY THERAPY	2,136	0	65.00
66.00	06600 PHYSICAL THERAPY	1,083	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	254	0	67.00
68.00	06800 SPEECH PATHOLOGY	260	0	68.00
69.00	06900 ELECTROCARDIOLOGY	5,196	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	111	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	1,304	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	10,373	0	73.00
76.00	03610 SLEEP LAB	0	0	76.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	8,338	0	90.00
91.00	09100 EMERGENCY	177,990	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	3,970	0	92.00
OTHER REIMBURSABLE COST CENTERS				
95.00	09500 AMBULANCE SERVICES	29,622		95.00
200.00	Subtotal (see instructions)	341,013	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00	Net Charges (line 200 - line 201)	341,013	0	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-1318	Period: From 01/01/2022 To 12/31/2022	Worksheet D-1 Date/Time Prepared: 5/31/2023 3:43 pm
Cost Center Description		Title XVIII	Hospital	Cost
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			4,961 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			3,468 2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.			0 3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)			2,900 4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			1,472 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			21 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)			1,122 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)			885 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			
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			
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)			9,531,920 21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)			0 22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)			0 23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)			0 24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)			0 25.00
26.00	Total swing-bed cost (see instructions)			2,840,283 26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			6,691,637 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)			6,691,637 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)			1,929.54 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			2,164,944 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)			2,164,944 41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-1318		Period: From 01/01/2022 To 12/31/2022		Worksheet D-1 Date/Time Prepared: 5/31/2023 3:43 pm	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Hospital Cost	
Cost Center Description		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	1,585,013	404	3,923.30	195	765,044	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)					1,684,215	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)					4,614,203	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
55.01	Permanent adjustment amount per discharge					0.00	55.01
55.02	Adjustment amount per discharge (contractor use only)					0.00	55.02
56.00	Target amount (line 54 x sum of lines 55, 55.01, and 55.02)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)					0.00	59.00
60.00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)					0.00	60.00
61.00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					1,707,643	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					1,707,643	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)					568	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,929.54	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					1,095,979	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-1318		Period: From 01/01/2022 To 12/31/2022		Worksheet D-1 Date/Time Prepared: 5/31/2023 3:43 pm	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	1,418,322	9,531,920	0.148797	1,095,979	163,078	90.00
91.00	Nursing Program cost	0	9,531,920	0.000000	1,095,979	0	91.00
92.00	Allied health cost	0	9,531,920	0.000000	1,095,979	0	92.00
93.00	All other Medical Education	0	9,531,920	0.000000	1,095,979	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-1318	Period: From 01/01/2022 To 12/31/2022	Worksheet D-1
		Title XIX	Hospital	Date/Time Prepared: 5/31/2023 3:43 pm
Cost Center Description				PPS
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		4,961	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		3,468	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		2,900	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		1,472	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		21	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)		51	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)		234	15.00
16.00	Nursery days (title V or XIX only)		21	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		9,531,920	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		2,840,283	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		6,691,637	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)		6,691,637	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)		1,929.54	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		98,407	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)		98,407	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 15-1318	Period: From 01/01/2022 To 12/31/2022	Worksheet D-1 Date/Time Prepared: 5/31/2023 3:43 pm		
Cost Center Description			Title XIX		Hospital	PPS	
	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)	779,743	234	3,332.24	21	69,977	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	1,585,013	404	3,923.30	2	7,847	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)					186,357	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)					362,588	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)					19,689	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					20,432	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					40,121	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthesiologist, and medical education costs (line 49 minus line 52)					322,467	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)					568	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,929.54	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					1,095,979	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-1318		Period: From 01/01/2022 To 12/31/2022		Worksheet D-1 Date/Time Prepared: 5/31/2023 3:43 pm	
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	1,418,322	9,531,920	0.148797	1,095,979	163,078	90.00
91.00	Nursing Program cost	0	9,531,920	0.000000	1,095,979	0	91.00
92.00	Allied health cost	0	9,531,920	0.000000	1,095,979	0	92.00
93.00	All other Medical Education	0	9,531,920	0.000000	1,095,979	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-1318	Period: From 01/01/2022 To 12/31/2022	Worksheet D-3 Date/Time Prepared: 5/31/2023 3:43 pm
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Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	Cost
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		2,862,703		30.00
31.00	03100 INTENSIVE CARE UNIT		722,508		31.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.165490	363,864	60,216	50.00
51.00	05100 RECOVERY ROOM	0.217805	64,698	14,092	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.084766	1,857,125	157,421	54.00
54.01	05401 ULTRASOUND	0.000000	0	0	54.01
56.00	05600 RADIOISOTOPE	0.000000	0	0	56.00
57.00	05700 CT SCAN	0.000000	0	0	57.00
58.00	05800 MRI	0.000000	0	0	58.00
60.00	06000 LABORATORY	0.135895	2,059,239	279,840	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0.251817	93,943	23,656	62.00
65.00	06500 RESPIRATORY THERAPY	0.278573	1,466,210	408,447	65.00
66.00	06600 PHYSICAL THERAPY	0.497839	256,263	127,578	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.197782	270,471	53,494	67.00
68.00	06800 SPEECH PATHOLOGY	0.386231	27,348	10,563	68.00
69.00	06900 ELECTROCARDIOLOGY	0.108686	653,901	71,070	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.017026	539,962	9,193	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.315568	6,781	2,140	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.104869	4,377,337	459,047	73.00
76.00	03610 SLEEP LAB	0.000000	0	0	76.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	2.717893	180	489	90.00
91.00	09100 EMERGENCY	0.263186	17,909	4,713	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.637235	3,540	2,256	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		12,058,771	1,684,215	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00	Net charges (line 200 minus line 201)		12,058,771		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-1318 Component CCN: 15-Z318	Period: From 01/01/2022 To 12/31/2022	Worksheet D-3 Date/Time Prepared: 5/31/2023 3:43 pm	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	Cost
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.165490	3,110	515
51.00	05100	RECOVERY ROOM	0.217805	5,422	1,181
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0
53.00	05300	ANESTHESIOLOGY	0.000000	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.084766	57,777	4,898
54.01	05401	ULTRASOUND	0.000000	0	0
56.00	05600	RADIOISOTOPE	0.000000	0	0
57.00	05700	CT SCAN	0.000000	0	0
58.00	05800	MRI	0.000000	0	0
60.00	06000	LABORATORY	0.135895	314,653	42,760
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.251817	9,541	2,403
65.00	06500	RESPIRATORY THERAPY	0.278573	797,709	222,220
66.00	06600	PHYSICAL THERAPY	0.497839	378,577	188,470
67.00	06700	OCCUPATIONAL THERAPY	0.197782	414,558	81,992
68.00	06800	SPEECH PATHOLOGY	0.386231	12,843	4,960
69.00	06900	ELECTROCARDIOLOGY	0.108686	6,908	751
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.017026	219,458	3,736
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.315568	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0.104869	1,123,686	117,840
76.00	03610	SLEEP LAB	0.000000	0	0
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	2.717893	0	0
91.00	09100	EMERGENCY	0.263186	0	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.637235	0	0
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES			95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		3,344,242	671,726
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0
202.00		Net charges (line 200 minus line 201)		3,344,242	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 15-1318	Period: From 01/01/2022 To 12/31/2022	Worksheet D-3 Date/Time Prepared: 5/31/2023 3:43 pm
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Cost Center Description		Ratio of Cost To Charges	Hospital Inpatient Program Charges	PPS Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		151,017		30.00
31.00	03100 INTENSIVE CARE UNIT		85,656		31.00
43.00	04300 NURSERY		21,003		43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.165490	168,596	27,901	50.00
51.00	05100 RECOVERY ROOM	0.217805	31,649	6,893	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.084766	166,979	14,154	54.00
54.01	05401 ULTRASOUND	0.000000	0	0	54.01
56.00	05600 RADIOISOTOPE	0.000000	0	0	56.00
57.00	05700 CT SCAN	0.000000	0	0	57.00
58.00	05800 MRI	0.000000	0	0	58.00
60.00	06000 LABORATORY	0.135895	168,682	22,923	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0.251817	10,349	2,606	62.00
65.00	06500 RESPIRATORY THERAPY	0.278573	90,908	25,325	65.00
66.00	06600 PHYSICAL THERAPY	0.497839	5,146	2,562	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.197782	5,012	991	67.00
68.00	06800 SPEECH PATHOLOGY	0.386231	4,247	1,640	68.00
69.00	06900 ELECTROCARDIOLOGY	0.108686	26,300	2,858	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.017026	37,401	637	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.315568	972	307	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.104869	389,668	40,864	73.00
76.00	03610 SLEEP LAB	0.000000	0	0	76.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	2.717893	2,295	6,238	90.00
91.00	09100 EMERGENCY	0.263186	87,586	23,051	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.637235	11,623	7,407	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		1,207,413	186,357	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00	Net charges (line 200 minus line 201)		1,207,413		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-1318	Period: From 01/01/2022 To 12/31/2022	Worksheet E Part B Date/Time Prepared: 5/31/2023 3:43 pm
		Title XVIII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			4,360,298 1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)			0 2.00
3.00	OPPS payments			5,457,313 3.00
4.00	Outlier payment (see instructions)			0 4.00
4.01	Outlier reconciliation amount (see instructions)			0 4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)			0.000 5.00
6.00	Line 2 times line 5			0 6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00 7.00
8.00	Transitional corridor payment (see instructions)			0 8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200			0 9.00
10.00	Organ acquisitions			0 10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)			4,360,298 11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges			0 12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)			0 13.00
14.00	Total reasonable charges (sum of lines 12 and 13)			0 14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0 15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a 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)			0 18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)			0 19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)			0 20.00
21.00	Lesser of cost or charges (see instructions)			4,403,901 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)			5,457,313 24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)			37,312 25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)			4,327,374 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)			39,215 27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)			0 28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0 29.00
30.00	Subtotal (sum of lines 27 through 29)			39,215 30.00
31.00	Primary payer payments			274 31.00
32.00	Subtotal (line 30 minus line 31)			38,941 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)			423,793 34.00
35.00	Adjusted reimbursable bad debts (see instructions)			275,465 35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			399,255 36.00
37.00	Subtotal (see instructions)			314,406 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)			0 39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION			0 39.99
40.00	Subtotal (see instructions)			314,406 40.00
40.01	Sequestration adjustment (see instructions)			3,962 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			1,078,467 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)			-768,023 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			0 44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)			0 90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			0 91.00
92.00	The rate used to calculate the Time Value of Money			0.00 92.00
93.00	Time Value of Money (see instructions)			0 93.00
94.00	Total (sum of lines 91 and 93)			0 94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1318	Period: From 01/01/2022 To 12/31/2022	Worksheet E Part B Date/Time Prepared: 5/31/2023 3:43 pm
Title XVIII		Hospital	Cost
			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: 15-1318

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

Worksheet E-1
Part I
Date/Time Prepared:
5/31/2023 3:43 pm

		Title XVIII		Hospital		Cost	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		3,761,793		1,078,467	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)		3,761,793		1,078,467	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		484,736		0	6.01	
6.02	SETTLEMENT TO PROGRAM		0		768,023	6.02	
7.00	Total Medicare program liability (see instructions)		4,246,529		310,444	7.00	
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor					8.00	

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-1318
Component CCN: 15-Z318

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

Worksheet E-1
Part I
Date/Time Prepared:
5/31/2023 3:43 pm

		Title XVIII		Swing Beds - SNF		Cost	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		1,963,354		0		1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0		2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						3.00
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		0		0		3.01
3.02			0		0		3.02
3.03			0		0		3.03
3.04			0		0		3.04
3.05			0		0		3.05
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0		0		3.50
3.51			0		0		3.51
3.52			0		0		3.52
3.53			0		0		3.53
3.54			0		0		3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0		3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,963,354		0		4.00
TO BE COMPLETED BY CONTRACTOR							
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						5.00
Program to Provider							
5.01	TENTATIVE TO PROVIDER		0		0		5.01
5.02			0		0		5.02
5.03			0		0		5.03
Provider to Program							
5.50	TENTATIVE TO PROGRAM		0		0		5.50
5.51			0		0		5.51
5.52			0		0		5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0		5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)						6.00
6.01	SETTLEMENT TO PROVIDER		372,270		0		6.01
6.02	SETTLEMENT TO PROGRAM		0		0		6.02
7.00	Total Medicare program liability (see instructions)		2,335,624		0		7.00
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor						8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 15-1318	Period: From 01/01/2022 To 12/31/2022	Worksheet E-1 Part II Date/Time Prepared: 5/31/2023 3:43 pm
		Title XVIII	Hospital	Cost
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14			1.00
2.00	Medicare days (see instructions)			2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			3.00
4.00	Total inpatient days (see instructions)			4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20			6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168			7.00
8.00	Calculation of the HIT incentive payment (see instructions)			8.00
9.00	Sequestration adjustment amount (see instructions)			9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			30.00
31.00	Other Adjustment (specify)			31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS		Provider CCN: 15-1318 Component CCN: 15-Z318	Period: From 01/01/2022 To 12/31/2022	Worksheet E-2 Date/Time Prepared: 5/31/2023 3:43 pm
		Title XVIII	Swing Beds - SNF	Cost
		Part A	Part B	
		1.00	2.00	
COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient routine services - swing bed-SNF (see instructions)	1,724,719	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swing-bed pass-through, see instructions)	678,443	0	3.00
3.01	Nursing and allied health payment-PARHM or CHART (see instructions)			3.01
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	885	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	2,403,162	0	8.00
9.00	Primary payer payments (see instructions)	0		9.00
10.00	Subtotal (line 8 minus line 9)	2,403,162	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	2,403,162	0	12.00
13.00	Coinurance billed to program patients (from provider records) (exclude coinurance for physician professional services)	37,733	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (see instructions)	2,365,429	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			16.50
16.55	Rural community hospital demonstration project (\$410A Demonstration) payment adjustment (see instructions)	0		16.55
16.99	Demonstration payment adjustment amount before sequestration	0	0	16.99
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	2,365,429	0	19.00
19.01	Sequestration adjustment (see instructions)	29,805	0	19.01
19.02	Demonstration payment adjustment amount after sequestration	0	0	19.02
19.03	Sequestration adjustment-PARHM or CHART pass-throughs			19.03
19.25	Sequestration for non-claims based amounts (see instructions)	0	0	19.25
20.00	Interim payments	1,963,354	0	20.00
20.01	Interim payments-PARHM or CHART			20.01
21.00	Tentative settlement (for contractor use only)	0	0	21.00
21.01	Tentative settlement-PARHM or CHART (for contractor use only)			21.01
22.00	Balance due provider/program (line 19 minus lines 19.01, 19.02, 19.25, 20, and 21)	372,270	0	22.00
22.01	Balance due provider/program-PARHM or CHART (see instructions)			22.01
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	23.00
Rural Community Hospital Demonstration Project (\$410A Demonstration) Adjustment				
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
Cost Reimbursement				
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))			201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))			202.00
203.00	Total (sum of lines 201 and 202)			203.00
204.00	Medicare swing-bed SNF discharges (see instructions)			204.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)				
205.00	Medicare swing-bed SNF target amount			205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)			206.00
Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement				
207.00	Program reimbursement under the \$410A Demonstration (see instructions)			207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)			208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
Comparison of PPS versus Cost Reimbursement				
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)			215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-1318	Period: From 01/01/2022 To 12/31/2022	Worksheet E-3 Part V Date/Time Prepared: 5/31/2023 3:43 pm
		Title XVIII	Hospital	Cost
				1.00
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT				
1.00	Inpatient services			4,614,203 1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)			0 2.00
3.00	Organ acquisition			0 3.00
3.01	Cellular therapy acquisition cost (see instructions)			0 3.01
4.00	Subtotal (sum of lines 1 through 3.01)			4,614,203 4.00
5.00	Primary payer payments			0 5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)			4,660,345 6.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
7.00	Routine service charges			0 7.00
8.00	Ancillary service charges			0 8.00
9.00	Organ acquisition charges, net of revenue			0 9.00
10.00	Total reasonable charges			0 10.00
Customary charges				
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0 11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)			0 12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)			0.000000 13.00
14.00	Total customary charges (see instructions)			0 14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)			0 15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)			0 16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)			0 17.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)			0 18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)			4,660,345 19.00
20.00	Deductibles (exclude professional component)			387,228 20.00
21.00	Excess reasonable cost (from line 16)			0 21.00
22.00	Subtotal (line 19 minus line 20 and 21)			4,273,117 22.00
23.00	Coinsurance			0 23.00
24.00	Subtotal (line 22 minus line 23)			4,273,117 24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			42,463 25.00
26.00	Adjusted reimbursable bad debts (see instructions)			27,601 26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			21,885 27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)			4,300,718 28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 29.50
29.98	Recovery of accelerated depreciation.			0 29.98
29.99	Demonstration payment adjustment amount before sequestration			0 29.99
30.00	Subtotal (see instructions)			4,300,718 30.00
30.01	Sequestration adjustment (see instructions)			54,189 30.01
30.02	Demonstration payment adjustment amount after sequestration			0 30.02
30.03	Sequestration adjustment-PARHM or CHART			0 30.03
31.00	Interim payments			3,761,793 31.00
31.01	Interim payments-PARHM or CHART			0 31.01
32.00	Tentative settlement (for contractor use only)			0 32.00
32.01	Tentative settlement-PARHM or CHART (for contractor use only)			0 32.01
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)			484,736 33.00
33.01	Balance due provider/program-PARHM or CHART (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01)			0 33.01
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-1318	Period: From 01/01/2022 To 12/31/2022	Worksheet E-3 Part VII Date/Time Prepared: 5/31/2023 3:43 pm	
		Title XIX	Hospital	PPS	
			Inpatient	Outpatient	
			1.00	2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES					
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient hospital/SNF/NF services		0		1.00
2.00	Medical and other services			341,013	2.00
3.00	Organ acquisition (certified transplant programs only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		0	341,013	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		0	341,013	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges		257,676		8.00
9.00	Ancillary service charges		1,207,413	1,984,400	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		1,465,089	1,984,400	12.00
CUSTOMARY CHARGES					
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		1,465,089	1,984,400	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		1,465,089	1,643,387	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		0	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		0	341,013	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.					
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0	0	24.00
25.00	Capital exception payments (see instructions)		0	0	25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		0	341,013	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		0	341,013	31.00
32.00	Deductibles		0	0	32.00
33.00	Coinurance		0	0	33.00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		0	0	35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		0	341,013	36.00
37.00	REMOVE SETTLEMENT		0	-341,013	37.00
38.00	Subtotal (line 36 ± line 37)		0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0	0	39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		0	0	40.00
41.00	Interim payments		0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)		0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2		0	0	43.00

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

Provider CCN: 15-1318

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

Worksheet G

Date/Time Prepared:
5/31/2023 3:43 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	-374,239	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	9,702,357	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-2,898,021	0	0	0	6.00
7.00	Inventory	933,117	0	0	0	7.00
8.00	Prepaid expenses	664,499	0	0	0	8.00
9.00	Other current assets	81,626	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)	8,109,339	0	0	0	11.00
FIXED ASSETS						
12.00	Land	500,000	0	0	0	12.00
13.00	Land improvements	246,545	0	0	0	13.00
14.00	Accumulated depreciation	-157,647	0	0	0	14.00
15.00	Buildings	10,619,283	0	0	0	15.00
16.00	Accumulated depreciation	-4,813,250	0	0	0	16.00
17.00	Leasehold improvements	11,120,591	0	0	0	17.00
18.00	Accumulated depreciation	-6,023,106	0	0	0	18.00
19.00	Fixed equipment	3,112,251	0	0	0	19.00
20.00	Accumulated depreciation	-2,076,813	0	0	0	20.00
21.00	Automobiles and trucks	583,590	0	0	0	21.00
22.00	Accumulated depreciation	-583,590	0	0	0	22.00
23.00	Major movable equipment	8,087,973	0	0	0	23.00
24.00	Accumulated depreciation	-5,492,152	0	0	0	24.00
25.00	Minor equipment depreciable	4,496,277	0	0	0	25.00
26.00	Accumulated depreciation	-3,364,325	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	16,255,627	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	6,279,797	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	6,279,797	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	30,644,763	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	2,322,144	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,658,630	0	0	0	38.00
39.00	Payroll taxes payable	133,695	0	0	0	39.00
40.00	Notes and loans payable (short term)	144,152	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	-37,831,714	0	0	0	43.00
44.00	Other current liabilities	364,715	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	-33,208,378	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	174,693	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	174,693	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	-33,033,685	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	63,678,448				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	63,678,448	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	30,644,763	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 15-1318

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

Worksheet G-1

Date/Time Prepared:
5/31/2023 3:43 pm

		General Fund		Special Purpose Fund		Endowment Fund
		1.00	2.00	3.00	4.00	5.00
1.00	Fund balances at beginning of period		59,334,283		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		4,344,165			2.00
3.00	Total (sum of line 1 and line 2)		63,678,448		0	3.00
4.00	Additions (credit adjustments) (specify)	0		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)		0		0	10.00
11.00	Subtotal (line 3 plus line 10)		63,678,448		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)		63,678,448		0	19.00
		Endowment Fund		Plant Fund		
		6.00	7.00	8.00		
1.00	Fund balances at beginning of period	0		0		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)					2.00
3.00	Total (sum of line 1 and line 2)	0		0		3.00
4.00	Additions (credit adjustments) (specify)		0			4.00
5.00			0			5.00
6.00			0			6.00
7.00			0			7.00
8.00			0			8.00
9.00			0			9.00
10.00	Total additions (sum of line 4-9)	0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0		11.00
12.00	Deductions (debit adjustments) (specify)		0			12.00
13.00			0			13.00
14.00			0			14.00
15.00			0			15.00
16.00			0			16.00
17.00			0			17.00
18.00	Total deductions (sum of lines 12-17)	0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0		19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 15-1318

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

Worksheet G-2
Parts I & II
Date/Time Prepared:
5/31/2023 3:43 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	10,420,192		10,420,192	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)	10,420,192		10,420,192	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	1,515,111		1,515,111	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)	1,515,111		1,515,111	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	11,935,303		11,935,303	17.00
18.00	Ancillary services	42,080,715	86,826,020	128,906,735	18.00
19.00	Outpatient services	4,356,621	28,075,357	32,431,978	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	0	11,718,028	11,718,028	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)	58,372,639	126,619,405	184,992,044	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		40,516,436		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)		40,516,436		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 15-1318

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

Worksheet G-3

Date/Time Prepared:
5/31/2023 3:43 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	184,992,044	1.00
2.00	Less contractual allowances and discounts on patients' accounts	141,495,155	2.00
3.00	Net patient revenues (line 1 minus line 2)	43,496,889	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	40,516,436	4.00
5.00	Net income from service to patients (line 3 minus line 4)	2,980,453	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	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	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER INCOME	120,099	24.00
24.50	COVID-19 PHE Funding	1,243,613	24.50
25.00	Total other income (sum of lines 6-24)	1,363,712	25.00
26.00	Total (line 5 plus line 25)	4,344,165	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	4,344,165	29.00