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: 15-0057	Period: From 01/01/2022 To 12/31/2022	Worksheet S Parts I-III Date/Time Prepared: 5/29/2023 3:28 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 5/29/2023 Time: 3:28 pm
2. [ ] Manually prepared cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no.

Contractor use only

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

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

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by FRANCISCAN HEALTH MOORESVILLE (15-0057) 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	CFO			3
4	Date				4

		Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	HOSPITAL	0	823,890	-26,472	0	0	1.00
2.00	SUBPROVIDER - IPF	0	0	0		0	2.00
3.00	SUBPROVIDER - IRF	0	0	0		0	3.00
5.00	SWING BED - SNF	0	0	0		0	5.00
6.00	SWING BED - NF	0				0	6.00
200.00	TOTAL	0	823,890	-26,472	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: 15-0057 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-2 Part I | Date/Time Prepared: 5/29/2023 3:28 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1201 HADLEY ROAD	PO Box:			1.00
2.00	City: MOORESVILLE	State: IN	Zip Code: 46158	County:	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	FRANCISCAN HEALTH MOORESVILLE	150057	26900	1	07/01/1996	N	P	P	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2022	12/31/2022	20.00
21.00	Type of Control (see instructions)	2		21.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0057 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-2 Part I | Date/Time Prepared: 5/29/2023 3:28 pm

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	54	0	0	4	1,627	87	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00

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

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

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

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? For cost reporting periods beginning prior to December 27, 2020, enter "Y" for yes or "N" for no in column 1. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.78(b)(2), see the instructions. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2.	N	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.	N			57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	N			58.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0057	Period: From 01/01/2022 To 12/31/2022	Worksheet S-2 Part I Date/Time Prepared: 5/29/2023 3:28 pm

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0057 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-2 Part I | Date/Time Prepared: 5/29/2023 3:28 pm

				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
				1.00	2.00	3.00	
	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.						
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	64.00
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00
				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
				1.00	2.00	3.00	
	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010						
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	66.00
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	67.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0057	Period: From 01/01/2022 To 12/31/2022	Worksheet S-2 Part I Date/Time Prepared: 5/29/2023 3:28 pm

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

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

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

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

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

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00

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

		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N	109.00

		1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration)for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.	N	110.00

		1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N		111.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0057 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-2 Part I | Date/Time Prepared: 5/29/2023 3:28 pm

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	240,838	0	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	Y	5.03	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	158014	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: FRANCISCAN ALLIANCE INC. AND AFFILI	Contractor's Name: WISCONSIN PHYSICIANS SERVICE	Contractor's Number: 08101	141.00
142.00	Street: 1515 W DRAGOON TRL	PO Box: 1290		142.00
143.00	City: MISHAWAKA	State: IN	Zip Code: 46544	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: 15-0057	Period: From 01/01/2022 To 12/31/2022	Worksheet S-2 Part I Date/Time Prepared: 5/29/2023 3:28 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	155.00
156.00	Subprovider - IPF	N	N	N	N	156.00
157.00	Subprovider - IRF	N	N	N	N	157.00
158.00	SUBPROVIDER					158.00
159.00	SNF	N	N	N	N	159.00
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00
161.00	CMHC		N	N	N	161.00

		1.00	
	Multicampus		
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.	N	165.00

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

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)		168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)		168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	9.99	169.00

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170.00

		1.00	2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N	0	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-0057 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-2 Part II | Date/Time Prepared: 5/29/2023 3:28 pm

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

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

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	05/06/2022	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	N		N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	04/27/2023	Y	04/27/2023	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: 15-0057 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-2 Part II Date/Time Prepared: 5/29/2023 3:28 pm

		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				N	33.00
	Provider-Based Physicians					
34.00	Were services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				N	35.00
				Y/N	Date	
				1.00	2.00	
	Home Office Costs					
36.00	Were home office costs claimed on the cost report?			Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			Y		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			Y		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			Y		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.	HONG		YANG		41.00
42.00	Enter the employer/company name of the cost report preparer.	FRANCISCAN HEALTH				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	219-407-6568		HONG.YANG@FRANCISCANALLIANCE.ORG		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-0057	Period: From 01/01/2022 To 12/31/2022	Worksheet S-2 Part II Date/Time Prepared: 5/29/2023 3:28 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.	DIRIECTOR OF REIMBURSEMENT		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-0057 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-3 Part I | Date/Time Prepared: 5/29/2023 3:28 pm

	Component	Worksheet A Line No.	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	70	25,550	0.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		70	25,550	0.00	0	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	34.00	10	3,650	0.00	0	11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		80	29,200	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		80				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: 15-0057 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-3 Part I | Date/Time Prepared: 5/29/2023 3:28 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,986	34	5,989			1.00
2.00	HMO and other (see instructions)	1,956	1,650				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,986	34	5,989			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	492	0	1,478			11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		1	584			13.00
14.00	Total (see instructions)	2,478	35	8,051	0.00	296.54	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	296.54	27.00
28.00	Observation Bed Days		284	1,773			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	87	126			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: 15-0057 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-3 Part I | Date/Time Prepared: 5/29/2023 3:28 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	732	13	2,256	1.00
2.00	HMO and other (see instructions)			397	642		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	732	13	2,256	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care						34.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0057 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-3 Part II Date/Time Prepared: 5/29/2023 3:28 pm

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	25,827,798	0	25,827,798	629,702.00	41.02	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician and Non Physician-Part B		0	0	0	0.00	0.00	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		538,575	0	538,575	13,521.00	39.83	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		572,805	0	572,805	5,254.25	109.02	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		88,636	0	88,636	594.06	149.20	13.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00	14.00
14.01	Home office salaries		3,434,152	0	3,434,152	98,171.00	34.98	14.01
14.02	Related organization salaries		0	0	0	0.00	0.00	14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00	16.01
16.02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.02
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		6,908,247	0	6,908,247			17.00
18.00	Wage-related costs (other) (see instructions)							18.00
19.00	Excluded areas		147,122	0	147,122			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		0	0	0			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
25.50	Home office wage-related (core)		986,940	0	986,940			25.50
25.51	Related organization wage-related (core)		0	0	0			25.51
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0			25.52

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0057 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-3 Part II Date/Time Prepared: 5/29/2023 3:28 pm

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.53	Home office: Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	0	0	0	0.00	0.00	26.00
27.00	Administrative & General	5.00	686,783	0	686,783	20,263.00	33.89	27.00
28.00	Administrative & General under contract (see inst.)		443,360	0	443,360	4,105.65	107.99	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	1,198,995	0	1,198,995	40,764.00	29.41	30.00
31.00	Laundry & Linen Service	8.00	46,954	0	46,954	2,645.00	17.75	31.00
32.00	Housekeeping	9.00	1,247,471	0	1,247,471	63,065.00	19.78	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	438,638	-314,318	124,320	5,440.00	22.85	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	37,693	314,318	352,011	15,634.00	22.52	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	589,353	0	589,353	11,131.00	52.95	38.00
39.00	Central Services and Supply	14.00	148,753	0	148,753	6,429.00	23.14	39.00
40.00	Pharmacy	15.00	1,084,459	0	1,084,459	22,356.00	48.51	40.00
41.00	Medical Records & Medical Records Library	16.00	0	0	0	0.00	0.00	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0057 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-3 Part III Date/Time Prepared: 5/29/2023 3:28 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		26,271,158	0	26,271,158	633,807.65	41.45	1.00
2.00	Excluded area salaries (see instructions)		538,575	0	538,575	13,521.00	39.83	2.00
3.00	Subtotal salaries (line 1 minus line 2)		25,732,583	0	25,732,583	620,286.65	41.48	3.00
4.00	Subtotal other wages & related costs (see inst.)		4,095,593	0	4,095,593	104,019.31	39.37	4.00
5.00	Subtotal wage-related costs (see inst.)		7,895,187	0	7,895,187	0.00	30.68	5.00
6.00	Total (sum of lines 3 thru 5)		37,723,363	0	37,723,363	724,305.96	52.08	6.00
7.00	Total overhead cost (see instructions)		5,922,459	0	5,922,459	191,832.65	30.87	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 15-0057 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-3 Part IV Date/Time Prepared: 5/29/2023 3:28 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	726,923	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)	1,343,775	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)	3,208,918	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	119,845	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	16,379	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)	139,522	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	316,827	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	2,227,117	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	0	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	8,099,306	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 15-0057 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-3 Part V | Date/Time Prepared: 5/29/2023 3:28 pm

	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	572,805	6,908,247	1.00
2.00	Hospital	572,805	6,908,247	2.00
3.00	SUBPROVIDER - IPF			3.00
4.00	SUBPROVIDER - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	SKILLED NURSING FACILITY			8.00
9.00	NURSING FACILITY			9.00
10.00	OTHER LONG TERM CARE I			10.00
11.00	Hospital-Based HHA			11.00
12.00	AMBULATORY SURGICAL CENTER (D.P.) I			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	RENAL DIALYSIS I	0	0	17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-0057 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-10 | Date/Time Prepared: 5/29/2023 3:28 pm

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.175148	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	14,182,892	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	N	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	N	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	95,830,516	6.00
7.00	Medicaid cost (line 1 times line 6)	16,784,523	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)	2,601,631	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)	2,601,631	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)	12,388,488	3,530,791	15,919,279	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	2,169,819	3,530,791	5,700,610	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	2,169,819	3,530,791	5,700,610	23.00

		1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	1,920,576	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	134,383	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	206,743	27.01
28.00	Non-Medicare bad debt expense (see instructions)	1,713,833	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	372,534	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	6,073,144	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	8,674,775	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0057 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A | Date/Time Prepared: 5/29/2023 3:28 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		3,584,321	3,584,321	2,200,402	5,784,723	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	160,266	160,266	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	6,233,597	6,233,597	0	6,233,597	4.00
5.01	00570	ADMITTING	0	1,643	1,643	-1,619	24	5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0	0	0	0	5.02
5.03	00590	OTHER ADMIN & GENERAL	686,783	7,062,588	7,749,371	-195,714	7,553,657	5.03
7.00	00700	OPERATION OF PLANT	1,198,995	3,243,997	4,442,992	-121,165	4,321,827	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	46,954	98,948	145,902	-1,069	144,833	8.00
9.00	00900	HOUSEKEEPING	1,247,471	307,360	1,554,831	-39,202	1,515,629	9.00
10.00	01000	DIETARY	438,638	183,786	622,424	-454,217	168,207	10.00
11.00	01100	CAFETERIA	37,693	135,196	172,889	400,688	573,577	11.00
13.00	01300	NURSING ADMINISTRATION	589,353	17,874	607,227	-7,649	599,578	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	148,753	132,684	281,437	-21,218	260,219	14.00
15.00	01500	PHARMACY	1,084,459	2,307,423	3,391,882	-2,281,839	1,110,043	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,138,708	3,397,031	8,535,739	-2,774,842	5,760,897	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	1,860,982	623,713	2,484,695	-182,577	2,302,118	34.00
43.00	04300	NURSERY	0	0	0	505,857	505,857	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,303,787	13,856,805	16,160,592	-13,515,080	2,645,512	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,668	169	1,837	1,797,427	1,799,264	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,008,801	796,536	2,805,337	-502,501	2,302,836	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	474,156	4,224,476	4,698,632	-591,051	4,107,581	55.00
60.00	06000	LABORATORY	0	3,540,242	3,540,242	-332,897	3,207,345	60.00
64.00	06400	INTRAVENOUS THERAPY	755,530	14,509,590	15,265,120	-14,235,718	1,029,402	64.00
65.00	06500	RESPIRATORY THERAPY	1,449,657	300,434	1,750,091	-250,055	1,500,036	65.00
66.00	06600	PHYSICAL THERAPY	1,598,502	83,312	1,681,814	-65,539	1,616,275	66.00
67.00	06700	OCCUPATIONAL THERAPY	222,437	14,107	236,544	-12,076	224,468	67.00
68.00	06800	SPEECH PATHOLOGY	31,992	3,050	35,042	-165	34,877	68.00
69.00	06900	ELECTROCARDIOLOGY	277,795	112,124	389,919	-20,162	369,757	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	14,898	57,818	72,716	-46,678	26,038	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	2,861,201	2,861,201	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	10,220,623	10,220,623	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	17,736,784	17,736,784	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CARE INSTITUTE	7,192	1,219	8,411	-1,219	7,192	90.01
90.02	09002	OP NUTRITIONAL COUNSELING	47,381	832	48,213	-347	47,866	90.02
91.00	09100	EMERGENCY	3,616,638	3,343,843	6,960,481	-500,344	6,460,137	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		-284,588	-284,588	284,588	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	25,289,223	67,890,130	93,179,353	12,893	93,192,246	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	41,677	64,967	106,644	0	106,644	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	284,506	172,556	457,062	-12,542	444,520	192.00
194.00	07950	COMMUNITY RELATIONS & MARKETING	0	0	0	0	0	194.00
194.01	07951	PLAINFIELD RADIOLOGY & PHYSICAL THE	212,392	193,299	405,691	0	405,691	194.01
194.02	07952	JV MV ENDOSCOPY	0	0	0	0	0	194.02
194.03	07953	SOUTHWEST CENTER FOR WOMENS HEALTH	0	0	0	0	0	194.03
194.04	07954	OTHER NRCC	0	17,784,413	17,784,413	-351	17,784,062	194.04
200.00		TOTAL (SUM OF LINES 118 through 199)	25,827,798	86,105,365	111,933,163	0	111,933,163	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0057 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A | Date/Time Prepared: 5/29/2023 3:28 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	1,266,298	7,051,021		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	160,266		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,204,023	7,437,620		4.00
5.01	00570	ADMITTING	0	24		5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0		5.02
5.03	00590	OTHER ADMIN & GENERAL	25,269,263	32,822,920		5.03
7.00	00700	OPERATION OF PLANT	907,801	5,229,628		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	-20,871	123,962		8.00
9.00	00900	HOUSEKEEPING	-21,038	1,494,591		9.00
10.00	01000	DIETARY	-1,068	167,139		10.00
11.00	01100	CAFETERIA	-249,091	324,486		11.00
13.00	01300	NURSING ADMINISTRATION	44,460	644,038		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-260,219	0		14.00
15.00	01500	PHARMACY	101,227	1,211,270		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	23,782	23,782		16.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0		21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0		22.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-4	5,760,893		30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	2,302,118		34.00
43.00	04300	NURSERY	0	505,857		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-1,588,765	1,056,747		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,799,264		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	137,973	2,440,809		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	-598,054	3,509,527		55.00
60.00	06000	LABORATORY	-65,398	3,141,947		60.00
64.00	06400	INTRAVENOUS THERAPY	-98,407	930,995		64.00
65.00	06500	RESPIRATORY THERAPY	-11,361	1,488,675		65.00
66.00	06600	PHYSICAL THERAPY	-6,282	1,609,993		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	224,468		67.00
68.00	06800	SPEECH PATHOLOGY	0	34,877		68.00
69.00	06900	ELECTROCARDIOLOGY	0	369,757		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	-6,495	19,543		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	2,861,201		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	10,220,623		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	17,736,784		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0		77.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
90.01	09001	WOUND CARE INSTITUTE	0	7,192		90.01
90.02	09002	OP NUTRITIONAL COUNSELING	0	47,866		90.02
91.00	09100	EMERGENCY	-47,415	6,412,722		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		OTHER REIMBURSABLE COST CENTERS				
102.00	10200	OPIOID TREATMENT PROGRAM	0	0		102.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	25,980,359	119,172,605		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	106,644		190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	444,520		192.00
194.00	07950	COMMUNITY RELATIONS & MARKETING	4	4		194.00
194.01	07951	PLAINFIELD RADIOLOGY & PHYSICAL THE	0	405,691		194.01
194.02	07952	JV MV ENDOSCOPY	0	0		194.02
194.03	07953	SOUTHWEST CENTER FOR WOMENS HEALTH	0	0		194.03
194.04	07954	OTHER NRCC	4,422,209	22,206,271		194.04
200.00		TOTAL (SUM OF LINES 118 through 199)	30,402,572	142,335,735		200.00

RECLASSIFICATIONS | Provider CCN: 15-0057 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-6 | Date/Time Prepared: 5/29/2023 3:28 pm

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - MEDICAL SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	2,861,201		1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	10,220,623		2.00
3.00	INTRAVENOUS THERAPY	64.00	0	1,399,819		3.00
4.00	OTHER ADMIN & GENERAL	5.03	0	25,354		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
19.00		0.00	0	0		19.00
20.00		0.00	0	0		20.00
21.00		0.00	0	0		21.00
22.00		0.00	0	0		22.00
23.00		0.00	0	0		23.00
24.00		0.00	0	0		24.00
25.00		0.00	0	0		25.00
27.00		0.00	0	0		27.00
	TOTALS		0	14,506,997		
	B - DRUGS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	17,736,784		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
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
14.00		0.00	0	0		14.00
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	17,736,784		
	C - EQUIPMENT LEASE					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	160,266		1.00
2.00	HOUSEKEEPING	9.00	0	570		2.00
3.00		0.00	0	0		3.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
	TOTALS		0	160,836		
	D - DEPRECIATION					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	2,484,990		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
21.00		0.00	0	0		21.00

RECLASSIFICATIONS | Provider CCN: 15-0057 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-6 | Date/Time Prepared: 5/29/2023 3:28 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
22.00		0.00	0	0		22.00
24.00		0.00	0	0		24.00
	TOTALS		0	2,484,990		
	E - EMPLOYEE BENEFITS					
1.00		0.00	0	0		1.00
	TOTALS		0	0		
	F - CAFETERIA					
1.00	CAFETERIA	11.00	314,318	110,835		1.00
	TOTALS		314,318	110,835		
	G - NURSERY					
1.00	NURSERY	43.00	423,142	82,715		1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	1,503,586	293,918		2.00
	TOTALS		1,926,728	376,633		
	H - CAPITALIZED INTEREST					
1.00	INTEREST EXPENSE	113.00	0	284,588		1.00
	TOTALS		0	284,588		
500.00	Grand Total: Increases		2,241,046	35,661,663		500.00

RECLASSIFICATIONS | Provider CCN: 15-0057 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-6 | Date/Time Prepared: 5/29/2023 3:28 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - MEDICAL SUPPLIES						
1.00	ADMITTING	5.01	0	1,619	9		1.00
2.00		0.00	0	0	0		2.00
3.00	OPERATION OF PLANT	7.00	0	1,032	0		3.00
4.00		0.00	0	0	0		4.00
5.00	HOUSEKEEPING	9.00	0	16,364	0		5.00
6.00	DIETARY	10.00	0	8,425	0		6.00
7.00	CAFETERIA	11.00	0	21,470	0		7.00
8.00	NURSING ADMINISTRATION	13.00	0	2,119	0		8.00
9.00	CENTRAL SERVICES & SUPPLY	14.00	0	16,464	0		9.00
10.00	PHARMACY	15.00	0	30,966	0		10.00
11.00	ADULTS & PEDIATRICS	30.00	0	299,759	0		11.00
12.00	SURGICAL INTENSIVE CARE UNIT	34.00	0	129,280	0		12.00
13.00	OPERATING ROOM	50.00	0	12,879,975	0		13.00
14.00	DELIVERY ROOM & LABOR ROOM	52.00	0	77	0		14.00
15.00	RADIOLOGY-DIAGNOSTIC	54.00	0	217,469	0		15.00
16.00	RADIOLOGY-THERAPEUTIC	55.00	0	1,404	0		16.00
17.00	LABORATORY	60.00	0	276,353	0		17.00
19.00	RESPIRATORY THERAPY	65.00	0	201,024	0		19.00
20.00	PHYSICAL THERAPY	66.00	0	11,805	0		20.00
21.00	OCCUPATIONAL THERAPY	67.00	0	12,076	0		21.00
22.00	SPEECH PATHOLOGY	68.00	0	165	0		22.00
23.00	ELECTROCARDIOLOGY	69.00	0	20,152	0		23.00
24.00	ELECTROENCEPHALOGRAPHY	70.00	0	14,820	0		24.00
25.00	WOUND CARE INSTITUTE	90.01	0	1,219	0		25.00
27.00	EMERGENCY	91.00	0	342,960	0		27.00
	TOTALS		0	14,506,997			
	B - DRUGS						
1.00	OTHER ADMIN & GENERAL	5.03	0	132	0		1.00
2.00	CENTRAL SERVICES & SUPPLY	14.00	0	461	0		2.00
3.00	PHARMACY	15.00	0	2,066,030	0		3.00
4.00	ADULTS & PEDIATRICS	30.00	0	3,899	0		4.00
5.00	SURGICAL INTENSIVE CARE UNIT	34.00	0	251	0		5.00
6.00	OPERATING ROOM	50.00	0	21,105	0		6.00
8.00	RADIOLOGY-DIAGNOSTIC	54.00	0	1,300	0		8.00
9.00	RADIOLOGY-THERAPEUTIC	55.00	0	55,383	0		9.00
10.00	LABORATORY	60.00	0	3	0		10.00
11.00	INTRAVENOUS THERAPY	64.00	0	15,552,221	0		11.00
12.00	RESPIRATORY THERAPY	65.00	0	681	0		12.00
14.00	ELECTROCARDIOLOGY	69.00	0	10	0		14.00
16.00	EMERGENCY	91.00	0	22,415	0		16.00
17.00	PHYSICIANS PRIVATE OFFICES	192.00	0	12,542	0		17.00
18.00	OTHER NRCC	194.04	0	351	0		18.00
	TOTALS		0	17,736,784			
	C - EQUIPMENT LEASE						
1.00		0.00		0	10		1.00
2.00	DIETARY	10.00		4,171	0		2.00
3.00	PHARMACY	15.00		150,738	0		3.00
5.00	RESPIRATORY THERAPY	65.00		5,625	0		5.00
6.00	EMERGENCY	91.00		302	0		6.00
	TOTALS		0	160,836			
	D - DEPRECIATION						
1.00	OPERATION OF PLANT	7.00	0	120,133	9		1.00
2.00	LAUNDRY & LINEN SERVICE	8.00	0	1,069	0		2.00
3.00	HOUSEKEEPING	9.00	0	23,408	0		3.00
4.00	DIETARY	10.00	0	16,468	0		4.00
5.00	CAFETERIA	11.00	0	2,995	0		5.00
6.00	NURSING ADMINISTRATION	13.00	0	5,530	0		6.00
7.00	CENTRAL SERVICES & SUPPLY	14.00	0	4,293	0		7.00
8.00	PHARMACY	15.00	0	34,105	0		8.00
9.00	ADULTS & PEDIATRICS	30.00	0	167,823	0		9.00
10.00	SURGICAL INTENSIVE CARE UNIT	34.00	0	53,046	0		10.00
11.00	OPERATING ROOM	50.00	0	614,000	0		11.00
12.00	RADIOLOGY-DIAGNOSTIC	54.00	0	283,732	0		12.00
13.00	RADIOLOGY-THERAPEUTIC	55.00	0	534,264	0		13.00
14.00	LABORATORY	60.00	0	56,541	0		14.00
15.00	INTRAVENOUS THERAPY	64.00	0	83,316	0		15.00
16.00	RESPIRATORY THERAPY	65.00	0	42,725	0		16.00
17.00	PHYSICAL THERAPY	66.00	0	53,734	0		17.00
18.00	OTHER ADMIN & GENERAL	5.03	0	220,936	0		18.00
19.00	ELECTROENCEPHALOGRAPHY	70.00	0	31,858	0		19.00
21.00	OP NUTRITIONAL COUNSELING	90.02	0	347	0		21.00
22.00	EMERGENCY	91.00	0	134,667	0		22.00
24.00		0.00	0	0	9		24.00

RECLASSIFICATIONS | Provider CCN: 15-0057 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-6 | Date/Time Prepared: 5/29/2023 3:28 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	TOTALS		0	2,484,990			
	E - EMPLOYEE BENEFITS						
1.00		0.00	0	0	0		1.00
	TOTALS		0	0			
	F - CAFETERIA						
1.00	DIETARY	10.00	314,318	110,835	0		1.00
	TOTALS		314,318	110,835			
	G - NURSERY						
1.00	ADULTS & PEDIATRICS	30.00	1,926,728	376,633	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		1,926,728	376,633			
	H - CAPITALIZED INTEREST						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	284,588	11		1.00
	TOTALS		0	284,588			
500.00	Grand Total: Decreases		2,241,046	35,661,663			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0057 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-7 Part I | Date/Time Prepared: 5/29/2023 3:28 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	0	0	0	0	0	1.00
2.00	Land Improvements	2,760,270	0	0	0	137,618	2.00
3.00	Buildings and Fixtures	62,794,372	491,262	0	491,262	0	3.00
4.00	Building Improvements	2,965,020	0	0	0	790,136	4.00
5.00	Fixed Equipment	46,025,820	308,701	0	308,701	0	5.00
6.00	Movable Equipment	27,982,025	1,695,019	0	1,695,019	36,936	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	142,527,507	2,494,982	0	2,494,982	964,690	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	142,527,507	2,494,982	0	2,494,982	964,690	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	0	0	1.00
2.00	Land Improvements	2,622,652	0	2.00
3.00	Buildings and Fixtures	63,285,634	0	3.00
4.00	Building Improvements	2,174,884	0	4.00
5.00	Fixed Equipment	46,334,521	0	5.00
6.00	Movable Equipment	29,640,108	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	144,057,799	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	144,057,799	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0057 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-7 Part II | Date/Time Prepared: 5/29/2023 3:28 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	3,584,321	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	3,584,321	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	3,584,321	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	2.00
3.00	Total (sum of lines 1-2)	0	3,584,321	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0057 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-7 Part III | Date/Time Prepared: 5/29/2023 3:28 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	111,795,040	0	111,795,040	0.799126	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	29,640,108	1,538,522	28,101,586	0.200874	0	2.00
3.00	Total (sum of lines 1-2)	141,435,148	1,538,522	139,896,626	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	6,197,973	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	160,266	2.00
3.00	Total (sum of lines 1-2)	0	0	0	6,197,973	160,266	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	853,048	0	0	0	7,051,021	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	160,266	2.00
3.00	Total (sum of lines 1-2)	853,048	0	0	0	7,211,287	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0057 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-8 | Date/Time Prepared: 5/29/2023 3:28 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)	B	-98,407	INTRAVENOUS THERAPY	64.00	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	-24,236	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	-2,983,924			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	38,669,403			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-260,783	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines	B	-8,467	CAFETERIA	11.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	CAFETERIA-EMPLOYEES AND GUESTS	B	0	ADULTS & PEDIATRICS	30.00	0	33.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0057 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-8 | Date/Time Prepared: 5/29/2023 3:28 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	
33.01	CAFETERIA-EMPLOYEES AND GUESTS	B	-14	OPERATING ROOM	50.00	0	33.01
33.02	CAFETERIA-EMPLOYEES AND GUESTS	B	0	RADIOLOGY-DIAGNOSTIC	54.00	0	33.02
33.03	MISC INCOME	B	-1,920,952	OTHER ADMIN & GENERAL	5.03	0	33.03
33.04	MISC INCOME	B	-81,089	OPERATION OF PLANT	7.00	0	33.04
33.05	MISC INCOME	B	-20,871	LAUNDRY & LINEN SERVICE	8.00	0	33.05
33.06	MISC INCOME	B	-21,038	HOUSEKEEPING	9.00	0	33.06
33.07	MISC INCOME	B	-1,068	DIETARY	10.00	0	33.07
33.08	MISC INCOME	B	20,159	CAFETERIA	11.00	0	33.08
33.09	MISC INCOME	B	-41,839	PHARMACY	15.00	0	33.09
33.10	MISC INCOME	B	-4	ADULTS & PEDIATRICS	30.00	0	33.10
33.11	MISC INCOME	B	0	SURGICAL INTENSIVE CARE UNIT	34.00	0	33.11
33.12	MISC INCOME	B	-13,418	OPERATING ROOM	50.00	0	33.12
33.13	MISC INCOME	B	-57,759	RADIOLOGY-DIAGNOSTIC	54.00	0	33.13
33.14	MISC INCOME	B	-598,054	RADIOLOGY-THERAPEUTIC	55.00	0	33.14
33.15	MISC INCOME	B	-2,511	RESPIRATORY THERAPY	65.00	0	33.15
33.16	MISC INCOME	B	-6,282	PHYSICAL THERAPY	66.00	0	33.16
33.17	DISCOUNTS	B	-260,219	CENTRAL SERVICES & SUPPLY	14.00	0	33.17
33.18	VENDING MACHINES	B	0	DIETARY	10.00	0	33.18
33.19	NEUROLOGY TESTING EXPENSES	A	0	ELECTROENCEPHALOGRAPHY	70.00	0	33.19
33.20	ON CALL COVERAGE	A	0	OTHER ADMIN & GENERAL	5.03	0	33.20
33.21	ON CALL COVERAGE	A	0	ADULTS & PEDIATRICS	30.00	0	33.21
33.22	NON ALLOWABLE INTEREST	A	0	CAP REL COSTS-BLDG & FIXT	1.00	11	33.22
33.23	HAF OFFSET	A	-2,869,032	OTHER ADMIN & GENERAL	5.03	0	33.23
33.24	PENSION ADJ PER REGS 2142.5	A	1,000,009	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.24
33.25	ADVERTISING	A	-1,766	OTHER ADMIN & GENERAL	5.03	0	33.25
33.26	DUES AND SUBSCRIPTIONS	A	-5,415	EMERGENCY	91.00	0	33.26
33.27	DUES AND SUBSCRIPTIONS	A	-7,020	OTHER ADMIN & GENERAL	5.03	0	33.27
33.28	MISC EXPENSE	A	0	OPERATION OF PLANT	7.00	0	33.28
33.29	MISC EXPENSE	A	0	HOUSEKEEPING	9.00	0	33.29
33.30	MISC EXPENSE	A	0	NURSING ADMINISTRATION	13.00	0	33.30
33.31	MISC EXPENSE	A	0	RADIOLOGY-DIAGNOSTIC	54.00	0	33.31
33.32	MISC EXPENSE	A	0	PHYSICAL THERAPY	66.00	0	33.32
33.33	DUES AND SUBSCRIPTIONS	A	-2,634	NURSING ADMINISTRATION	13.00	0	33.33
34.00	OTHER HOSP LOCATION	A	-155	CAP REL COSTS-BLDG & FIXT	1.00	9	34.00
34.01	OTHER HOSP LOCATION	A	0		0.00	0	34.01
34.02	OTHER HOSP LOCATION	A	0		0.00	0	34.02
34.03	OTHER HOSP LOCATION	A	0		0.00	0	34.03
34.04	OTHER HOSP LOCATION	A	0		0.00	0	34.04
34.05	OTHER HOSP LOCATION	A	0		0.00	0	34.05
35.00	NON-HOSP LOCATION	B	-42	OTHER ADMIN & GENERAL	5.03	0	35.00
35.01	NON-HOSP LOCATION	A	0	OTHER ADMIN & GENERAL	5.03	0	35.01
35.02	NON-HOSP LOCATION	A	0	CENTRAL SERVICES & SUPPLY	14.00	0	35.02
35.03	NON-HOSP LOCATION	A	0	LABORATORY	60.00	0	35.03
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		30,402,572				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: 15-0057 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-8-1 | Date/Time Prepared: 5/29/2023 3:28 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	1.00	CAP REL COSTS-BLDG & FIXT	SHARED SERVICE ALLOCATION	128,817	0	1.00
2.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	SHARED SERVICE ALLOCATION	204,014	0	2.00
3.00	5.03	OTHER ADMIN & GENERAL	SHARED SERVICE ALLOCATION	13,283,429	0	3.00
4.00	7.00	OPERATION OF PLANT	SHARED SERVICE ALLOCAITON	1,014,251	0	4.00
4.01	13.00	NURSING ADMINISTRATION	SHARED SERVICE ALLOCATION	47,094	0	4.01
4.02	16.00	MEDICAL RECORDS & LIBRARY	SHARED SERVICE ALLOCATION	23,782	0	4.02
4.03	54.00	RADIOLOGY-DIAGNOSTIC	SHARED SERVICE ALLOCATION	195,732	0	4.03
4.04	0.00			0	0	4.04
4.05	194.00	COMMUNITY RELATIONS & MARKET	SHARED SERVICE ALLOCATION	4	0	4.05
4.06	194.04	OTHER NRCC	SHARED SERVICE ALLOCATION	4,422,209	0	4.06
4.07	60.00	LABORATORY	SHARED SERVICE ALLOCATION	3,149,818	3,215,216	4.07
4.08	5.03	OTHER ADMIN & GENERAL	FRANCISCAN HOME OFFICE	16,540,989	0	4.08
4.09	1.00	CAP REL COSTS-BLDG & FIXT	FRANCISCAN HOME OFFICE	1,137,636	0	4.09
4.10	5.03	OTHER ADMIN & GENERAL	FRANCISCAN HOME OFFICE	935,972	0	4.10
4.11	5.03	OTHER ADMIN & GENERAL	FRANCISCAN HOME OFFICE	657,806	0	4.11
4.12	15.00	PHARMACY	FRANCISCAN HOME OFFICE	143,066	0	4.12
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			41,884,619	3,215,216	5.00

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

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

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

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

6.00	B	HOME OFFICE	100.00	FRANC. ALLIANCE	100.00	6.00
7.00	B	APHL	100.00	APHL	100.00	7.00
8.00	G	FH CENTRAL INDY	100.00	FRANC. HEALTH	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: 15-0057 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-8-1 | Date/Time Prepared: 5/29/2023 3:28 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	128,817	9		1.00
2.00	204,014	0		2.00
3.00	13,283,429	0		3.00
4.00	1,014,251	0		4.00
4.01	47,094	0		4.01
4.02	23,782	0		4.02
4.03	195,732	0		4.03
4.04	0	0		4.04
4.05	4	0		4.05
4.06	4,422,209	0		4.06
4.07	-65,398	0		4.07
4.08	16,540,989	0		4.08
4.09	1,137,636	11		4.09
4.10	935,972	0		4.10
4.11	657,806	0		4.11
4.12	143,066	0		4.12
5.00	38,669,403			5.00

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

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

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

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

6.00	HEALTH SYSTEM		6.00
7.00	SHARED LAB		7.00
8.00	HOSPITAL		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: 15-0057 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-8-2 | Date/Time Prepared: 5/29/2023 3:28 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.03	OTHER ADMIN & GENERAL	1,350,121	1,350,121	0	179,000	0	1.00
2.00	7.00	OPERATION OF PLANT	1,125	1,125	0	179,000	0	2.00
3.00	50.00	OPERATING ROOM	1,575,333	1,575,333	0	179,000	0	3.00
4.00	65.00	RESPIRATORY THERAPY	8,850	8,850	0	0	0	4.00
5.00	70.00	ELECTROENCEPHALOGRAPHY	6,495	6,495	0	0	0	5.00
6.00	91.00	EMERGENCY	42,000	42,000	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			2,983,924	2,983,924	0		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.03	OTHER ADMIN & GENERAL	0	0	0	0	0	1.00
2.00	7.00	OPERATION OF PLANT	0	0	0	0	0	2.00
3.00	50.00	OPERATING ROOM	0	0	0	0	0	3.00
4.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	4.00
5.00	70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	5.00
6.00	91.00	EMERGENCY	0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.03	OTHER ADMIN & GENERAL	0	0	0	1,350,121		1.00
2.00	7.00	OPERATION OF PLANT	0	0	0	1,125		2.00
3.00	50.00	OPERATING ROOM	0	0	0	1,575,333		3.00
4.00	65.00	RESPIRATORY THERAPY	0	0	0	8,850		4.00
5.00	70.00	ELECTROENCEPHALOGRAPHY	0	0	0	6,495		5.00
6.00	91.00	EMERGENCY	0	0	0	42,000		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	2,983,924		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0057 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part I | Date/Time Prepared: 5/29/2023 3:28 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	ADMITTING	
			0	1.00	2.00	4.00	5.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	7,051,021	7,051,021				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	160,266		160,266			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	7,437,620	0	0	7,437,620		4.00
5.01	00570	ADMITTING	24	61,653	1,401	0	63,078	5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0	0	0	0	5.02
5.03	00590	OTHER ADMIN & GENERAL	32,822,920	173,821	3,951	197,773	0	5.03
7.00	00700	OPERATION OF PLANT	5,229,628	1,476,668	33,564	345,275	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	123,962	22,773	518	13,521	0	8.00
9.00	00900	HOUSEKEEPING	1,494,591	112,299	2,552	359,234	0	9.00
10.00	01000	DIETARY	167,139	86,780	1,972	35,800	0	10.00
11.00	01100	CAFETERIA	324,486	74,517	1,694	101,369	0	11.00
13.00	01300	NURSING ADMINISTRATION	644,038	2,772	63	169,716	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	49,338	1,121	42,836	0	14.00
15.00	01500	PHARMACY	1,211,270	52,110	1,184	312,292	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	23,782	0	0	0	0	16.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,760,893	934,785	21,247	924,954	8,777	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	2,302,118	206,975	4,704	535,907	3,047	34.00
43.00	04300	NURSERY	505,857	0	0	121,852	670	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,056,747	576,344	13,100	663,422	10,412	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,799,264	0	0	433,468	2,938	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,440,809	215,551	4,899	578,474	2,921	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	3,509,527	180,331	4,099	136,543	166	55.00
60.00	06000	LABORATORY	3,141,947	101,526	2,308	0	4,141	60.00
64.00	06400	INTRAVENOUS THERAPY	930,995	0	0	217,570	446	64.00
65.00	06500	RESPIRATORY THERAPY	1,488,675	58,542	1,331	417,458	2,203	65.00
66.00	06600	PHYSICAL THERAPY	1,609,993	181,508	4,126	460,321	1,144	66.00
67.00	06700	OCCUPATIONAL THERAPY	224,468	106,651	2,424	64,055	127	67.00
68.00	06800	SPEECH PATHOLOGY	34,877	0	0	9,213	70	68.00
69.00	06900	ELECTROCARDIOLOGY	369,757	24,970	568	79,997	752	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	19,543	81,655	1,856	4,290	46	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,861,201	0	0	0	7,211	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	10,220,623	0	0	0	6,640	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	17,736,784	0	0	0	4,783	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	70,674	1,606	0	13	90.00
90.01	09001	WOUND CARE INSTITUTE	7,192	0	0	2,071	4	90.01
90.02	09002	OP NUTRITIONAL COUNSELING	47,866	0	0	13,644	0	90.02
91.00	09100	EMERGENCY	6,412,722	336,451	7,647	1,041,471	6,567	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	119,172,605	5,188,694	117,935	7,282,526	63,078	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	106,644	28,813	655	12,002	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	444,520	0	0	81,929	0	192.00
194.00	07950	COMMUNITY RELATIONS & MARKETING	4	0	0	0	0	194.00
194.01	07951	PLAINFIELD RADIOLOGY & PHYSICAL THE	405,691	0	0	61,163	0	194.01
194.02	07952	JV MV ENDOSCOPY	0	0	0	0	0	194.02
194.03	07953	SOUTHWEST CENTER FOR WOMENS HEALTH	0	0	0	0	0	194.03
194.04	07954	OTHER NRCC	22,206,271	1,833,514	41,676	0	0	194.04
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)	142,335,735	7,051,021	160,266	7,437,620	63,078	202.00

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		Cost Center Description	CASHIERING/ACCOUNTS RECEIVABLE	Subtotal	OTHER ADMIN & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			5.02	5A.02	5.03	7.00	8.00	
		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	00580	CASHIERING/ACCOUNTS RECEIVABLE	0					5.02
5.03	00590	OTHER ADMIN & GENERAL	0	33,198,465	33,198,465			5.03
7.00	00700	OPERATION OF PLANT	0	7,085,135	2,155,227	9,240,362		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	160,774	48,906	39,416	249,096	8.00
9.00	00900	HOUSEKEEPING	0	1,968,676	598,852	194,363	0	9.00
10.00	01000	DIETARY	0	291,691	88,729	150,196	0	10.00
11.00	01100	CAFETERIA	0	502,066	152,723	128,972	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	816,589	248,398	4,797	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	93,295	28,379	85,393	0	14.00
15.00	01500	PHARMACY	0	1,576,856	479,664	90,190	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	23,782	7,234	0	0	16.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	7,650,656	2,327,253	1,617,896	53,120	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	3,052,751	928,616	358,225	18,007	34.00
43.00	04300	NURSERY	0	628,379	191,147	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	2,320,025	705,728	997,519	46,100	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	2,235,670	680,068	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,242,654	986,383	373,068	35,867	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	3,830,666	1,165,250	312,112	183	55.00
60.00	06000	LABORATORY	0	3,249,922	988,594	175,719	20	60.00
64.00	06400	INTRAVENOUS THERAPY	0	1,149,011	349,518	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	1,968,209	598,709	101,322	0	65.00
66.00	06600	PHYSICAL THERAPY	0	2,257,092	686,585	314,148	6,688	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	397,725	120,984	184,588	1,905	67.00
68.00	06800	SPEECH PATHOLOGY	0	44,160	13,433	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	476,044	144,808	43,217	3,481	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	107,390	32,667	141,326	284	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	2,868,412	872,542	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	10,227,263	3,111,031	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	17,741,567	5,396,807	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	72,293	21,991	122,320	0	90.00
90.01	09001	WOUND CARE INSTITUTE	0	9,267	2,819	0	0	90.01
90.02	09002	OP NUTRITIONAL COUNSELING	0	61,510	18,711	0	0	90.02
91.00	09100	EMERGENCY	0	7,804,858	2,374,160	582,319	54,388	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0				92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	117,112,853	25,525,916	6,017,106	220,043	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	148,114	45,055	49,869	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	526,449	160,141	0	16	192.00
194.00	07950	COMMUNITY RELATIONS & MARKETING	0	4	1	0	0	194.00
194.01	07951	PLAINFIELD RADIOLOGY & PHYSICAL THE	0	466,854	142,012	0	0	194.01
194.02	07952	JV MV ENDOSCOPY	0	0	0	0	0	194.02
194.03	07953	SOUTHWEST CENTER FOR WOMENS HEALTH	0	0	0	0	0	194.03
194.04	07954	OTHER NRCC	0	24,081,461	7,325,340	3,173,387	29,037	194.04
200.00		Cross Foot Adjustments		0				200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	142,335,735	33,198,465	9,240,362	249,096	202.00

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		Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			9.00	10.00	11.00	13.00	14.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
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	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.02
5.03	00590	OTHER ADMIN & GENERAL						5.03
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	2,761,891					9.00
10.00	01000	DIETARY	46,058	576,674				10.00
11.00	01100	CAFETERIA	39,550	0	823,311			11.00
13.00	01300	NURSING ADMINISTRATION	1,471	0	21,033	1,092,288		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	26,186	0	0	0	233,253	14.00
15.00	01500	PHARMACY	27,657	0	42,243	314	192	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	496,132	428,977	215,582	423,011	379	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	109,851	105,866	64,485	159,126	116	34.00
43.00	04300	NURSERY	0	41,831	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	305,892	0	89,579	127,124	1,671	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	23	65	1	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	114,402	0	98,352	0	122	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	95,710	0	15,018	8,316	19	55.00
60.00	06000	LABORATORY	53,885	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	50,061	125	64.00
65.00	06500	RESPIRATORY THERAPY	31,071	0	46,270	0	19	65.00
66.00	06600	PHYSICAL THERAPY	96,334	0	73,285	0	108	66.00
67.00	06700	OCCUPATIONAL THERAPY	56,604	0	10,102	0	17	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	1,245	0	2	68.00
69.00	06900	ELECTROCARDIOLOGY	13,253	0	8,673	0	23	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	43,338	0	518	0	7	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71,137	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	158,888	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	37,510	0	0	0	0	90.00
90.01	09001	WOUND CARE INSTITUTE	0	0	0	687	0	90.01
90.02	09002	OP NUTRITIONAL COUNSELING	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	178,570	0	132,565	323,443	375	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,773,474	576,674	818,973	1,092,147	233,201	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	15,292	0	4,338	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	141	34	192.00
194.00	07950	COMMUNITY RELATIONS & MARKETING	0	0	0	0	0	194.00
194.01	07951	PLAINFIELD RADIOLOGY & PHYSICAL THE	0	0	0	0	4	194.01
194.02	07952	JV MV ENDOSCOPY	0	0	0	0	0	194.02
194.03	07953	SOUTHWEST CENTER FOR WOMENS HEALTH	0	0	0	0	0	194.03
194.04	07954	OTHER NRCC	973,125	0	0	0	14	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	2,761,891	576,674	823,311	1,092,288	233,253	202.00

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		Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES APPRV	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS APPRV	Subtotal	
			15.00	16.00	21.00	22.00	24.00	
		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	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.02
5.03	00590	OTHER ADMIN & GENERAL						5.03
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	2,217,116					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	31,016				16.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0		0		22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	1,268	0	0	13,214,274	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	305	0	0	4,797,348	34.00
43.00	04300	NURSERY	0	67	0	0	861,424	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	2,740	0	0	4,596,378	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	296	0	0	2,916,123	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,459	0	0	4,854,307	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	2,029	0	0	5,429,303	55.00
60.00	06000	LABORATORY	0	2,095	0	0	4,470,235	60.00
64.00	06400	INTRAVENOUS THERAPY	0	651	0	0	1,549,366	64.00
65.00	06500	RESPIRATORY THERAPY	0	458	0	0	2,746,058	65.00
66.00	06600	PHYSICAL THERAPY	0	674	0	0	3,434,914	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	112	0	0	772,037	67.00
68.00	06800	SPEECH PATHOLOGY	0	16	0	0	58,856	68.00
69.00	06900	ELECTROCARDIOLOGY	0	868	0	0	690,367	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	102	0	0	325,632	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,710	0	0	3,813,801	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,021	0	0	13,499,203	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,217,116	6,262	0	0	25,361,752	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	6	0	0	254,120	90.00
90.01	09001	WOUND CARE INSTITUTE	0	1	0	0	12,774	90.01
90.02	09002	OP NUTRITIONAL COUNSELING	0	4	0	0	80,225	90.02
91.00	09100	EMERGENCY	0	5,872	0	0	11,456,550	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,217,116	31,016	0	0	105,195,047	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	262,668	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	686,781	192.00
194.00	07950	COMMUNITY RELATIONS & MARKETING	0	0	0	0	5	194.00
194.01	07951	PLAINFIELD RADIOLOGY & PHYSICAL THE	0	0	0	0	608,870	194.01
194.02	07952	JV MV ENDOSCOPY	0	0	0	0	0	194.02
194.03	07953	SOUTHWEST CENTER FOR WOMENS HEALTH	0	0	0	0	0	194.03
194.04	07954	OTHER NRCC	0	0	0	0	35,582,364	194.04
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	2,217,116	31,016	0	0	142,335,735	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0057 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part I | Date/Time Prepared: 5/29/2023 3:28 pm

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
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	00580	CASHIERING/ACCOUNTS RECEIVABLE				5.02
5.03	00590	OTHER ADMIN & GENERAL				5.03
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
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV				21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV				22.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	13,214,274		30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	4,797,348		34.00
43.00	04300	NURSERY	0	861,424		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	4,596,378		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	2,916,123		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	4,854,307		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	5,429,303		55.00
60.00	06000	LABORATORY	0	4,470,235		60.00
64.00	06400	INTRAVENOUS THERAPY	0	1,549,366		64.00
65.00	06500	RESPIRATORY THERAPY	0	2,746,058		65.00
66.00	06600	PHYSICAL THERAPY	0	3,434,914		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	772,037		67.00
68.00	06800	SPEECH PATHOLOGY	0	58,856		68.00
69.00	06900	ELECTROCARDIOLOGY	0	690,367		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	325,632		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	3,813,801		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	13,499,203		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	25,361,752		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0		77.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	254,120		90.00
90.01	09001	WOUND CARE INSTITUTE	0	12,774		90.01
90.02	09002	OP NUTRITIONAL COUNSELING	0	80,225		90.02
91.00	09100	EMERGENCY	0	11,456,550		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0			92.00
		OTHER REIMBURSABLE COST CENTERS				
102.00	10200	OPIOID TREATMENT PROGRAM	0	0		102.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	105,195,047		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	262,668		190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	686,781		192.00
194.00	07950	COMMUNITY RELATIONS & MARKETING	0	5		194.00
194.01	07951	PLAINFIELD RADIOLOGY & PHYSICAL THE	0	608,870		194.01
194.02	07952	JV MV ENDOSCOPY	0	0		194.02
194.03	07953	SOUTHWEST CENTER FOR WOMENS HEALTH	0	0		194.03
194.04	07954	OTHER NRCC	0	35,582,364		194.04
200.00		Cross Foot Adjustments	0	0		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	0	142,335,735		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0057 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part II | Date/Time Prepared: 5/29/2023 3:28 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.01	00570	ADMITTING	0	61,653	1,401	63,054	0	5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0	0	0	0	5.02
5.03	00590	OTHER ADMIN & GENERAL	0	173,821	3,951	177,772	0	5.03
7.00	00700	OPERATION OF PLANT	0	1,476,668	33,564	1,510,232	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	22,773	518	23,291	0	8.00
9.00	00900	HOUSEKEEPING	0	112,299	2,552	114,851	0	9.00
10.00	01000	DIETARY	0	86,780	1,972	88,752	0	10.00
11.00	01100	CAFETERIA	0	74,517	1,694	76,211	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	2,772	63	2,835	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	49,338	1,121	50,459	0	14.00
15.00	01500	PHARMACY	0	52,110	1,184	53,294	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	934,785	21,247	956,032	0	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	206,975	4,704	211,679	0	34.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	576,344	13,100	589,444	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	215,551	4,899	220,450	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	180,331	4,099	184,430	0	55.00
60.00	06000	LABORATORY	0	101,526	2,308	103,834	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	58,542	1,331	59,873	0	65.00
66.00	06600	PHYSICAL THERAPY	0	181,508	4,126	185,634	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	106,651	2,424	109,075	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	24,970	568	25,538	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	81,655	1,856	83,511	0	70.00
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
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	70,674	1,606	72,280	0	90.00
90.01	09001	WOUND CARE INSTITUTE	0	0	0	0	0	90.01
90.02	09002	OP NUTRITIONAL COUNSELING	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	0	336,451	7,647	344,098	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	5,188,694	117,935	5,306,629	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	28,813	655	29,468	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	COMMUNITY RELATIONS & MARKETING	0	0	0	0	0	194.00
194.01	07951	PLAINFIELD RADIOLOGY & PHYSICAL THE	0	0	0	0	0	194.01
194.02	07952	JV MV ENDOSCOPY	0	0	0	0	0	194.02
194.03	07953	SOUTHWEST CENTER FOR WOMENS HEALTH	0	0	0	0	0	194.03
194.04	07954	OTHER NRCC	0	1,833,514	41,676	1,875,190	0	194.04
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	7,051,021	160,266	7,211,287	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0057 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part II | Date/Time Prepared: 5/29/2023 3:28 pm

		Cost Center Description	ADMITTING	CASHIERING/ACCOUNTS RECEIVABLE	OTHER ADMIN & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			5.01	5.02	5.03	7.00	8.00	
		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	63,054					5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0				5.02
5.03	00590	OTHER ADMIN & GENERAL	0	0	177,772			5.03
7.00	00700	OPERATION OF PLANT	0	0	11,542	1,521,774		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	262	6,491	30,044	8.00
9.00	00900	HOUSEKEEPING	0	0	3,207	32,009	0	9.00
10.00	01000	DIETARY	0	0	475	24,735	0	10.00
11.00	01100	CAFETERIA	0	0	818	21,240	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	1,330	790	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	152	14,063	0	14.00
15.00	01500	PHARMACY	0	0	2,569	14,853	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	39	0	0	16.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,777	0	12,463	266,448	6,407	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	3,047	0	4,973	58,995	2,172	34.00
43.00	04300	NURSERY	670	0	1,024	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,388	0	3,779	164,279	5,560	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,938	0	3,642	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,921	0	5,282	61,440	4,326	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	166	0	6,240	51,401	22	55.00
60.00	06000	LABORATORY	4,141	0	5,294	28,939	2	60.00
64.00	06400	INTRAVENOUS THERAPY	446	0	1,872	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	2,203	0	3,206	16,687	0	65.00
66.00	06600	PHYSICAL THERAPY	1,144	0	3,677	51,736	807	66.00
67.00	06700	OCCUPATIONAL THERAPY	127	0	648	30,399	230	67.00
68.00	06800	SPEECH PATHOLOGY	70	0	72	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	752	0	775	7,117	420	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	46	0	175	23,275	34	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	7,211	0	4,673	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,640	0	16,660	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,783	0	28,901	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	13	0	118	20,145	0	90.00
90.01	09001	WOUND CARE INSTITUTE	4	0	15	0	0	90.01
90.02	09002	OP NUTRITIONAL COUNSELING	0	0	100	0	0	90.02
91.00	09100	EMERGENCY	6,567	0	12,714	95,901	6,560	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	63,054	0	136,697	990,943	26,540	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	241	8,213	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	858	0	2	192.00
194.00	07950	COMMUNITY RELATIONS & MARKETING	0	0	0	0	0	194.00
194.01	07951	PLAINFIELD RADIOLOGY & PHYSICAL THE	0	0	761	0	0	194.01
194.02	07952	JV MV ENDOSCOPY	0	0	0	0	0	194.02
194.03	07953	SOUTHWEST CENTER FOR WOMENS HEALTH	0	0	0	0	0	194.03
194.04	07954	OTHER NRCC	0	0	39,215	522,618	3,502	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	63,054	0	177,772	1,521,774	30,044	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0057 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part II | Date/Time Prepared: 5/29/2023 3:28 pm

		Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			9.00	10.00	11.00	13.00	14.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
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	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.02
5.03	00590	OTHER ADMIN & GENERAL						5.03
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	150,067					9.00
10.00	01000	DIETARY	2,503	116,465				10.00
11.00	01100	CAFETERIA	2,149	0	100,418			11.00
13.00	01300	NURSING ADMINISTRATION	80	0	2,565	7,600		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,423	0	0	0	66,097	14.00
15.00	01500	PHARMACY	1,503	0	5,152	2	54	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	26,957	86,636	26,295	2,945	107	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	5,969	21,381	7,865	1,107	33	34.00
43.00	04300	NURSERY	0	8,448	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	16,621	0	10,926	884	473	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	3	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,216	0	11,996	0	35	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	5,200	0	1,832	58	5	55.00
60.00	06000	LABORATORY	2,928	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	348	35	64.00
65.00	06500	RESPIRATORY THERAPY	1,688	0	5,643	0	5	65.00
66.00	06600	PHYSICAL THERAPY	5,234	0	8,938	0	31	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,076	0	1,232	0	5	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	152	0	1	68.00
69.00	06900	ELECTROCARDIOLOGY	720	0	1,058	0	6	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	2,355	0	63	0	2	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	20,157	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	45,027	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,038	0	0	0	0	90.00
90.01	09001	WOUND CARE INSTITUTE	0	0	0	5	0	90.01
90.02	09002	OP NUTRITIONAL COUNSELING	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	9,703	0	16,169	2,250	106	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	96,363	116,465	99,889	7,599	66,082	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	831	0	529	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	1	10	192.00
194.00	07950	COMMUNITY RELATIONS & MARKETING	0	0	0	0	0	194.00
194.01	07951	PLAINFIELD RADIOLOGY & PHYSICAL THE	0	0	0	0	1	194.01
194.02	07952	JV MV ENDOSCOPY	0	0	0	0	0	194.02
194.03	07953	SOUTHWEST CENTER FOR WOMENS HEALTH	0	0	0	0	0	194.03
194.04	07954	OTHER NRCC	52,873	0	0	0	4	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	150,067	116,465	100,418	7,600	66,097	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0057 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part II | Date/Time Prepared: 5/29/2023 3:28 pm

		Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES APPRV	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS APPRV	Subtotal	
			15.00	16.00	21.00	22.00	24.00	
		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	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.02
5.03	00590	OTHER ADMIN & GENERAL						5.03
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	77,427					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	39				16.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0		0		22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0			1,393,067	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0			317,221	34.00
43.00	04300	NURSERY	0	0			10,142	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0			802,354	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0			6,583	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0			312,666	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0			249,354	55.00
60.00	06000	LABORATORY	0	0			145,138	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0			2,701	64.00
65.00	06500	RESPIRATORY THERAPY	0	0			89,305	65.00
66.00	06600	PHYSICAL THERAPY	0	0			257,201	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0			144,792	67.00
68.00	06800	SPEECH PATHOLOGY	0	0			295	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0			36,386	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0			109,461	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0			32,041	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0			68,327	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	77,427	39			111,150	73.00
74.00	07400	RENAL DIALYSIS	0	0			0	74.00
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0			0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0			94,594	90.00
90.01	09001	WOUND CARE INSTITUTE	0	0			24	90.01
90.02	09002	OP NUTRITIONAL COUNSELING	0	0			100	90.02
91.00	09100	EMERGENCY	0	0			494,068	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0			0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	77,427	39	0	0	4,676,970	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0			39,282	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0			871	192.00
194.00	07950	COMMUNITY RELATIONS & MARKETING	0	0			0	194.00
194.01	07951	PLAINFIELD RADIOLOGY & PHYSICAL THE	0	0			762	194.01
194.02	07952	JV MV ENDOSCOPY	0	0			0	194.02
194.03	07953	SOUTHWEST CENTER FOR WOMENS HEALTH	0	0			0	194.03
194.04	07954	OTHER NRCC	0	0			2,493,402	194.04
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	77,427	39	0	0	7,211,287	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0057 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part II | Date/Time Prepared: 5/29/2023 3:28 pm

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
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	00580	CASHIERING/ACCOUNTS RECEIVABLE				5.02
5.03	00590	OTHER ADMIN & GENERAL				5.03
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
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV				21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV				22.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	1,393,067		30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	317,221		34.00
43.00	04300	NURSERY	0	10,142		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	802,354		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	6,583		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	312,666		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	249,354		55.00
60.00	06000	LABORATORY	0	145,138		60.00
64.00	06400	INTRAVENOUS THERAPY	0	2,701		64.00
65.00	06500	RESPIRATORY THERAPY	0	89,305		65.00
66.00	06600	PHYSICAL THERAPY	0	257,201		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	144,792		67.00
68.00	06800	SPEECH PATHOLOGY	0	295		68.00
69.00	06900	ELECTROCARDIOLOGY	0	36,386		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	109,461		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	32,041		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	68,327		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	111,150		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0		77.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	94,594		90.00
90.01	09001	WOUND CARE INSTITUTE	0	24		90.01
90.02	09002	OP NUTRITIONAL COUNSELING	0	100		90.02
91.00	09100	EMERGENCY	0	494,068		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0			92.00
		OTHER REIMBURSABLE COST CENTERS				
102.00	10200	OPIOID TREATMENT PROGRAM	0	0		102.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	4,676,970		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	39,282		190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	871		192.00
194.00	07950	COMMUNITY RELATIONS & MARKETING	0	0		194.00
194.01	07951	PLAINFIELD RADIOLOGY & PHYSICAL THE	0	762		194.01
194.02	07952	JV MV ENDOSCOPY	0	0		194.02
194.03	07953	SOUTHWEST CENTER FOR WOMENS HEALTH	0	0		194.03
194.04	07954	OTHER NRCC	0	2,493,402		194.04
200.00		Cross Foot Adjustments	0	0		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	0	7,211,287		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0057 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B-1 | Date/Time Prepared: 5/29/2023 3:28 pm

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	ADMITTING (INPATIENT CHARGES)	CASHIERING/ACCOUNTS RECEIVABLE (GROSS CHARGES)	
			1.00	2.00	4.00	5.01	5.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	269,675					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		269,675				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	25,827,798			4.00
5.01	00570	ADMITTING	2,358	2,358	0	121,608,032		5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0	0	0	600,605,494	5.02
5.03	00590	OTHER ADMIN & GENERAL	6,648	6,648	686,783	0	0	5.03
7.00	00700	OPERATION OF PLANT	56,477	56,477	1,198,995	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	871	871	46,954	0	0	8.00
9.00	00900	HOUSEKEEPING	4,295	4,295	1,247,471	0	0	9.00
10.00	01000	DIETARY	3,319	3,319	124,320	0	0	10.00
11.00	01100	CAFETERIA	2,850	2,850	352,011	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	106	106	589,353	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,887	1,887	148,753	0	0	14.00
15.00	01500	PHARMACY	1,993	1,993	1,084,459	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	35,752	35,752	3,211,980	16,911,907	24,383,690	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	7,916	7,916	1,860,982	5,870,900	5,870,900	34.00
43.00	04300	NURSERY	0	0	423,142	1,291,146	1,291,146	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	22,043	22,043	2,303,787	20,132,649	52,694,137	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	1,505,254	5,661,483	5,689,284	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,244	8,244	2,008,801	5,627,278	66,516,452	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	6,897	6,897	474,156	319,728	39,018,603	55.00
60.00	06000	LABORATORY	3,883	3,883	0	7,978,950	40,288,271	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	755,530	859,923	12,524,228	64.00
65.00	06500	RESPIRATORY THERAPY	2,239	2,239	1,449,657	4,244,313	8,809,308	65.00
66.00	06600	PHYSICAL THERAPY	6,942	6,942	1,598,502	2,205,075	12,969,374	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,079	4,079	222,437	244,082	2,162,671	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	31,992	134,547	311,856	68.00
69.00	06900	ELECTROCARDIOLOGY	955	955	277,795	1,449,587	16,686,687	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	3,123	3,123	14,898	89,080	1,963,054	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	13,893,336	32,875,486	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	12,792,958	38,868,522	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	9,215,726	124,558,646	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,703	2,703	0	24,529	123,863	90.00
90.01	09001	WOUND CARE INSTITUTE	0	0	7,192	7,684	15,303	90.01
90.02	09002	OP NUTRITIONAL COUNSELING	0	0	47,381	0	67,994	90.02
91.00	09100	EMERGENCY	12,868	12,868	3,616,638	12,653,151	112,916,019	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	198,448	198,448	25,289,223	121,608,032	600,605,494	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	1,102	1,102	41,677	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	284,506	0	0	192.00
194.00	07950	COMMUNITY RELATIONS & MARKETING	0	0	0	0	0	194.00
194.01	07951	PLAINFIELD RADIOLOGY & PHYSICAL THE	0	0	212,392	0	0	194.01
194.02	07952	JV MV ENDOSCOPY	0	0	0	0	0	194.02
194.03	07953	SOUTHWEST CENTER FOR WOMENS HEALTH	0	0	0	0	0	194.03
194.04	07954	OTHER NRCC	70,125	70,125	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	7,051,021	160,266	7,437,620	63,078	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	26.146365	0.594293	0.287970	0.000519	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			0	63,054	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000000	0.000519	0.000000	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0057 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B-1 | Date/Time Prepared: 5/29/2023 3:28 pm

		Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	ADMITTING (INPATIENT CHARGES)	CASHIERING/ACCOUNTS RECEIVABLE (GROSS CHARGES)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
			1.00	2.00	4.00	5.01	5.02	
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0057 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B-1 | Date/Time Prepared: 5/29/2023 3:28 pm

		Cost Center Description	Reconciliation	OTHER ADMIN & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	
			5A.03	5.03	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	ADMITTING						5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.02
5.03	00590	OTHER ADMIN & GENERAL	-33,198,465	109,137,270				5.03
7.00	00700	OPERATION OF PLANT	0	7,085,135	204,192			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	160,774	871	367,212		8.00
9.00	00900	HOUSEKEEPING	0	1,968,676	4,295	0	199,026	9.00
10.00	01000	DIETARY	0	291,691	3,319	0	3,319	10.00
11.00	01100	CAFETERIA	0	502,066	2,850	0	2,850	11.00
13.00	01300	NURSING ADMINISTRATION	0	816,589	106	0	106	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	93,295	1,887	0	1,887	14.00
15.00	01500	PHARMACY	0	1,576,856	1,993	0	1,993	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	23,782	0	0	0	16.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	7,650,656	35,752	78,309	35,752	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	3,052,751	7,916	26,545	7,916	34.00
43.00	04300	NURSERY	0	628,379	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	2,320,025	22,043	67,959	22,043	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	2,235,670	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,242,654	8,244	52,875	8,244	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	3,830,666	6,897	270	6,897	55.00
60.00	06000	LABORATORY	0	3,249,922	3,883	29	3,883	60.00
64.00	06400	INTRAVENOUS THERAPY	0	1,149,011	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	1,968,209	2,239	0	2,239	65.00
66.00	06600	PHYSICAL THERAPY	0	2,257,092	6,942	9,859	6,942	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	397,725	4,079	2,809	4,079	67.00
68.00	06800	SPEECH PATHOLOGY	0	44,160	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	476,044	955	5,131	955	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	107,390	3,123	418	3,123	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	2,868,412	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	10,227,263	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	17,741,567	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	72,293	2,703	0	2,703	90.00
90.01	09001	WOUND CARE INSTITUTE	0	9,267	0	0	0	90.01
90.02	09002	OP NUTRITIONAL COUNSELING	0	61,510	0	0	0	90.02
91.00	09100	EMERGENCY	0	7,804,858	12,868	80,178	12,868	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-33,198,465	83,914,388	132,965	324,382	127,799	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	148,114	1,102	0	1,102	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	526,449	0	24	0	192.00
194.00	07950	COMMUNITY RELATIONS & MARKETING	0	4	0	0	0	194.00
194.01	07951	PLAINFIELD RADIOLOGY & PHYSICAL THE	0	466,854	0	0	0	194.01
194.02	07952	JV MV ENDOSCOPY	0	0	0	0	0	194.02
194.03	07953	SOUTHWEST CENTER FOR WOMENS HEALTH	0	0	0	0	0	194.03
194.04	07954	OTHER NRCC	0	24,081,461	70,125	42,806	70,125	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)		33,198,465	9,240,362	249,096	2,761,891	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)		0.304190	45.253301	0.678344	13.877036	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		177,772	1,521,774	30,044	150,067	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.001629	7.452662	0.081816	0.754007	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: 15-0057 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B-1 | Date/Time Prepared: 5/29/2023 3:28 pm

		Cost Center Description	DIETARY (GROSS PATIENT DAYS)	CAFETERIA (FTES)	NURSING ADMINISTRATION (DIRECT NURSING)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
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	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.02
5.03	00590	OTHER ADMIN & GENERAL						5.03
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	8,051					10.00
11.00	01100	CAFETERIA	0	435,713				11.00
13.00	01300	NURSING ADMINISTRATION	0	11,131	202,023			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	15,004,291		14.00
15.00	01500	PHARMACY	0	22,356	58	12,321	100	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,989	114,090	78,238	24,387	0	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	1,478	34,127	29,431	7,491	0	34.00
43.00	04300	NURSERY	584	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	47,407	23,512	107,473	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	12	12	76	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	52,050	0	7,877	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	7,948	1,538	1,224	0	55.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	9,259	8,021	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	24,487	0	1,227	0	65.00
66.00	06600	PHYSICAL THERAPY	0	38,784	0	6,976	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	5,346	0	1,109	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	659	0	146	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	4,590	0	1,467	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	274	0	482	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	4,575,916	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	10,220,623	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	100	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	13	0	90.00
90.01	09001	WOUND CARE INSTITUTE	0	0	127	0	0	90.01
90.02	09002	OP NUTRITIONAL COUNSELING	0	0	0	26	0	90.02
91.00	09100	EMERGENCY	0	70,156	59,822	24,108	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	8,051	433,417	201,997	15,000,963	100	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	2,296	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	26	2,190	0	192.00
194.00	07950	COMMUNITY RELATIONS & MARKETING	0	0	0	0	0	194.00
194.01	07951	PLAINFIELD RADIOLOGY & PHYSICAL THE	0	0	0	257	0	194.01
194.02	07952	JV MV ENDOSCOPY	0	0	0	0	0	194.02
194.03	07953	SOUTHWEST CENTER FOR WOMENS HEALTH	0	0	0	0	0	194.03
194.04	07954	OTHER NRCC	0	0	0	881	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	576,674	823,311	1,092,288	233,253	2,217,116	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	71.627624	1.889572	5.406751	0.015546	22,171.160000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	116,465	100,418	7,600	66,097	77,427	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	14.465905	0.230468	0.037619	0.004405	774.270000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0057 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B-1 | Date/Time Prepared: 5/29/2023 3:28 pm

		Cost Center Description	DIETARY (GROSS PATIENT DAYS)	CAFETERIA (FTES)	NURSING ADMINISTRATION (DIRECT NURSING)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
			10.00	11.00	13.00	14.00	15.00	
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0057 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B-1 | Date/Time Prepared: 5/29/2023 3:28 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES APPRV (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS APPRV (ASSIGNED TIME)		
			16.00	21.00	22.00		
		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	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.02
5.03	00590	OTHER ADMIN & GENERAL					5.03
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	600,605,494				16.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0		0		22.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	24,383,690	0	0		30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	5,870,900	0	0		34.00
43.00	04300	NURSERY	1,291,146	0	0		43.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	52,694,137	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	5,689,284	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	66,516,452	0	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	39,018,603	0	0		55.00
60.00	06000	LABORATORY	40,288,271	0	0		60.00
64.00	06400	INTRAVENOUS THERAPY	12,524,228	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	8,809,308	0	0		65.00
66.00	06600	PHYSICAL THERAPY	12,969,374	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	2,162,671	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	311,856	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	16,686,687	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,963,054	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	32,875,486	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	38,868,522	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	124,558,646	0	0		73.00
74.00	07400	RENAL DIALYSIS	0	0	0		74.00
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0		77.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	123,863	0	0		90.00
90.01	09001	WOUND CARE INSTITUTE	15,303	0	0		90.01
90.02	09002	OP NUTRITIONAL COUNSELING	67,994	0	0		90.02
91.00	09100	EMERGENCY	112,916,019	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
		OTHER REIMBURSABLE COST CENTERS					
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0		102.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	600,605,494	0	0		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0		190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0		192.00
194.00	07950	COMMUNITY RELATIONS & MARKETING	0	0	0		194.00
194.01	07951	PLAINFIELD RADIOLOGY & PHYSICAL THE	0	0	0		194.01
194.02	07952	JV MV ENDOSCOPY	0	0	0		194.02
194.03	07953	SOUTHWEST CENTER FOR WOMENS HEALTH	0	0	0		194.03
194.04	07954	OTHER NRCC	0	0	0		194.04
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	31,016	0	0		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000052	0.000000	0.000000		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	39	0	0		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	0.000000	0.000000		205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0057 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B-1 | Date/Time Prepared: 5/29/2023 3:28 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES APPRV (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS APPRV (ASSIGNED TIME)		
			16.00	21.00	22.00		
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)					206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)					207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0057 | Period: From 01/01/2022 To 12/31/2022 | Worksheet C Part I Date/Time Prepared: 5/29/2023 3:28 pm

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		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	13,214,274		13,214,274	0	13,214,274	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	4,797,348		4,797,348	0	4,797,348	34.00
43.00	04300	NURSERY	861,424		861,424	0	861,424	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,596,378		4,596,378	0	4,596,378	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,916,123		2,916,123	0	2,916,123	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,854,307		4,854,307	0	4,854,307	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	5,429,303		5,429,303	0	5,429,303	55.00
60.00	06000	LABORATORY	4,470,235		4,470,235	0	4,470,235	60.00
64.00	06400	INTRAVENOUS THERAPY	1,549,366		1,549,366	0	1,549,366	64.00
65.00	06500	RESPIRATORY THERAPY	2,746,058	0	2,746,058	0	2,746,058	65.00
66.00	06600	PHYSICAL THERAPY	3,434,914	0	3,434,914	0	3,434,914	66.00
67.00	06700	OCCUPATIONAL THERAPY	772,037	0	772,037	0	772,037	67.00
68.00	06800	SPEECH PATHOLOGY	58,856	0	58,856	0	58,856	68.00
69.00	06900	ELECTROCARDIOLOGY	690,367		690,367	0	690,367	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	325,632		325,632	0	325,632	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,813,801		3,813,801	0	3,813,801	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	13,499,203		13,499,203	0	13,499,203	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	25,361,752		25,361,752	0	25,361,752	73.00
74.00	07400	RENAL DIALYSIS	0		0	0	0	74.00
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0		0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	254,120		254,120	0	254,120	90.00
90.01	09001	WOUND CARE INSTITUTE	12,774		12,774	0	12,774	90.01
90.02	09002	OP NUTRITIONAL COUNSELING	80,225		80,225	0	80,225	90.02
91.00	09100	EMERGENCY	11,456,550		11,456,550	0	11,456,550	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	3,018,408		3,018,408		3,018,408	92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0		0		0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	108,213,455	0	108,213,455	0	108,213,455	200.00
201.00		Less Observation Beds	3,018,408		3,018,408		3,018,408	201.00
202.00		Total (see instructions)	105,195,047	0	105,195,047	0	105,195,047	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0057 | Period: From 01/01/2022 To 12/31/2022 | Worksheet C Part I Date/Time Prepared: 5/29/2023 3:28 pm

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		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	15,589,382		15,589,382			30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	5,870,900		5,870,900			34.00
43.00	04300	NURSERY	1,291,146		1,291,146			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	20,132,649	32,561,488	52,694,137	0.087228	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	5,661,483	27,801	5,689,284	0.512564	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,627,278	60,889,174	66,516,452	0.072979	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	319,728	38,698,875	39,018,603	0.139147	0.000000	55.00
60.00	06000	LABORATORY	7,978,950	32,309,321	40,288,271	0.110956	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	859,923	11,664,305	12,524,228	0.123710	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	4,244,313	4,564,995	8,809,308	0.311722	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	2,205,075	10,764,299	12,969,374	0.264848	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	244,082	1,918,589	2,162,671	0.356983	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	134,547	177,309	311,856	0.188728	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	1,449,587	15,237,100	16,686,687	0.041372	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	89,080	1,873,974	1,963,054	0.165880	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	13,893,336	18,982,150	32,875,486	0.116007	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	12,792,958	26,075,564	38,868,522	0.347304	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,215,726	115,342,920	124,558,646	0.203613	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0.000000	0.000000	74.00
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0.000000	0.000000	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	24,529	99,334	123,863	2.051622	0.000000	90.00
90.01	09001	WOUND CARE INSTITUTE	7,684	7,619	15,303	0.834738	0.000000	90.01
90.02	09002	OP NUTRITIONAL COUNSELING	0	67,994	67,994	1.179884	0.000000	90.02
91.00	09100	EMERGENCY	12,653,151	100,262,868	112,916,019	0.101461	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,322,525	7,471,783	8,794,308	0.343223	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0			102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	121,608,032	478,997,462	600,605,494			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	121,608,032	478,997,462	600,605,494			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0057 | Period: From 01/01/2022 To 12/31/2022 | Worksheet C Part I Date/Time Prepared: 5/29/2023 3:28 pm

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		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT		34.00
43.00	04300	NURSERY		43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.087228	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.512564	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.072979	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.139147	55.00
60.00	06000	LABORATORY	0.110956	60.00
64.00	06400	INTRAVENOUS THERAPY	0.123710	64.00
65.00	06500	RESPIRATORY THERAPY	0.311722	65.00
66.00	06600	PHYSICAL THERAPY	0.264848	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.356983	67.00
68.00	06800	SPEECH PATHOLOGY	0.188728	68.00
69.00	06900	ELECTROCARDIOLOGY	0.041372	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.165880	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.116007	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.347304	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.203613	73.00
74.00	07400	RENAL DIALYSIS	0.000000	74.00
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0.000000	77.00
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	2.051622	90.00
90.01	09001	WOUND CARE INSTITUTE	0.834738	90.01
90.02	09002	OP NUTRITIONAL COUNSELING	1.179884	90.02
91.00	09100	EMERGENCY	0.101461	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.343223	92.00
		OTHER REIMBURSABLE COST CENTERS		
102.00	10200	OPIOID TREATMENT PROGRAM		102.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0057 | Period: From 01/01/2022 To 12/31/2022 | Worksheet C Part I Date/Time Prepared: 5/29/2023 3:28 pm

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		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	13,214,274		13,214,274	0	13,214,274	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	4,797,348		4,797,348	0	4,797,348	34.00
43.00	04300	NURSERY	861,424		861,424	0	861,424	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,596,378		4,596,378	0	4,596,378	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,916,123		2,916,123	0	2,916,123	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,854,307		4,854,307	0	4,854,307	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	5,429,303		5,429,303	0	5,429,303	55.00
60.00	06000	LABORATORY	4,470,235		4,470,235	0	4,470,235	60.00
64.00	06400	INTRAVENOUS THERAPY	1,549,366		1,549,366	0	1,549,366	64.00
65.00	06500	RESPIRATORY THERAPY	2,746,058	0	2,746,058	0	2,746,058	65.00
66.00	06600	PHYSICAL THERAPY	3,434,914	0	3,434,914	0	3,434,914	66.00
67.00	06700	OCCUPATIONAL THERAPY	772,037	0	772,037	0	772,037	67.00
68.00	06800	SPEECH PATHOLOGY	58,856	0	58,856	0	58,856	68.00
69.00	06900	ELECTROCARDIOLOGY	690,367		690,367	0	690,367	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	325,632		325,632	0	325,632	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,813,801		3,813,801	0	3,813,801	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	13,499,203		13,499,203	0	13,499,203	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	25,361,752		25,361,752	0	25,361,752	73.00
74.00	07400	RENAL DIALYSIS	0		0	0	0	74.00
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0		0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	254,120		254,120	0	254,120	90.00
90.01	09001	WOUND CARE INSTITUTE	12,774		12,774	0	12,774	90.01
90.02	09002	OP NUTRITIONAL COUNSELING	80,225		80,225	0	80,225	90.02
91.00	09100	EMERGENCY	11,456,550		11,456,550	0	11,456,550	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	3,018,408		3,018,408		3,018,408	92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0		0		0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	108,213,455	0	108,213,455	0	108,213,455	200.00
201.00		Less Observation Beds	3,018,408		3,018,408		3,018,408	201.00
202.00		Total (see instructions)	105,195,047	0	105,195,047	0	105,195,047	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0057 | Period: From 01/01/2022 To 12/31/2022 | Worksheet C Part I Date/Time Prepared: 5/29/2023 3:28 pm

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		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	15,589,382		15,589,382			30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	5,870,900		5,870,900			34.00
43.00	04300	NURSERY	1,291,146		1,291,146			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	20,132,649	32,561,488	52,694,137	0.087228	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	5,661,483	27,801	5,689,284	0.512564	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,627,278	60,889,174	66,516,452	0.072979	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	319,728	38,698,875	39,018,603	0.139147	0.000000	55.00
60.00	06000	LABORATORY	7,978,950	32,309,321	40,288,271	0.110956	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	859,923	11,664,305	12,524,228	0.123710	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	4,244,313	4,564,995	8,809,308	0.311722	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	2,205,075	10,764,299	12,969,374	0.264848	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	244,082	1,918,589	2,162,671	0.356983	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	134,547	177,309	311,856	0.188728	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	1,449,587	15,237,100	16,686,687	0.041372	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	89,080	1,873,974	1,963,054	0.165880	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	13,893,336	18,982,150	32,875,486	0.116007	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	12,792,958	26,075,564	38,868,522	0.347304	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,215,726	115,342,920	124,558,646	0.203613	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0.000000	0.000000	74.00
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0.000000	0.000000	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	24,529	99,334	123,863	2.051622	0.000000	90.00
90.01	09001	WOUND CARE INSTITUTE	7,684	7,619	15,303	0.834738	0.000000	90.01
90.02	09002	OP NUTRITIONAL COUNSELING	0	67,994	67,994	1.179884	0.000000	90.02
91.00	09100	EMERGENCY	12,653,151	100,262,868	112,916,019	0.101461	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,322,525	7,471,783	8,794,308	0.343223	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0			102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	121,608,032	478,997,462	600,605,494			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	121,608,032	478,997,462	600,605,494			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0057 | Period: From 01/01/2022 To 12/31/2022 | Worksheet C Part I Date/Time Prepared: 5/29/2023 3:28 pm

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		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT			34.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.087228		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.512564		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.072979		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.139147		55.00
60.00	06000	LABORATORY	0.110956		60.00
64.00	06400	INTRAVENOUS THERAPY	0.123710		64.00
65.00	06500	RESPIRATORY THERAPY	0.311722		65.00
66.00	06600	PHYSICAL THERAPY	0.264848		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.356983		67.00
68.00	06800	SPEECH PATHOLOGY	0.188728		68.00
69.00	06900	ELECTROCARDIOLOGY	0.041372		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.165880		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.116007		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.347304		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.203613		73.00
74.00	07400	RENAL DIALYSIS	0.000000		74.00
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0.000000		77.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	2.051622		90.00
90.01	09001	WOUND CARE INSTITUTE	0.834738		90.01
90.02	09002	OP NUTRITIONAL COUNSELING	1.179884		90.02
91.00	09100	EMERGENCY	0.101461		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.343223		92.00
		OTHER REIMBURSABLE COST CENTERS			
102.00	10200	OPIOID TREATMENT PROGRAM			102.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

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

Provider CCN: 15-0057 | Period: From 01/01/2022 To 12/31/2022 | Worksheet C Part II Date/Time Prepared: 5/29/2023 3:28 pm

Title XIX | Hospital | PPS

		Cost Center Description	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	4,596,378	802,354	3,794,024	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,916,123	6,583	2,909,540	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,854,307	312,666	4,541,641	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	5,429,303	249,354	5,179,949	0	0	55.00
60.00	06000	LABORATORY	4,470,235	145,138	4,325,097	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	1,549,366	2,701	1,546,665	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	2,746,058	89,305	2,656,753	0	0	65.00
66.00	06600	PHYSICAL THERAPY	3,434,914	257,201	3,177,713	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	772,037	144,792	627,245	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	58,856	295	58,561	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	690,367	36,386	653,981	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	325,632	109,461	216,171	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,813,801	32,041	3,781,760	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	13,499,203	68,327	13,430,876	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	25,361,752	111,150	25,250,602	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	254,120	94,594	159,526	0	0	90.00
90.01	09001	WOUND CARE INSTITUTE	12,774	24	12,750	0	0	90.01
90.02	09002	OP NUTRITIONAL COUNSELING	80,225	100	80,125	0	0	90.02
91.00	09100	EMERGENCY	11,456,550	494,068	10,962,482	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	3,018,408	318,204	2,700,204	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (sum of lines 50 thru 199)	89,340,409	3,274,744	86,065,665	0	0	200.00
201.00		Less Observation Beds	3,018,408	318,204	2,700,204	0	0	201.00
202.00		Total (line 200 minus line 201)	86,322,001	2,956,540	83,365,461	0	0	202.00

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

Provider CCN: 15-0057 | Period: From 01/01/2022 To 12/31/2022 | Worksheet C Part II Date/Time Prepared: 5/29/2023 3:28 pm

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		Cost Center Description	Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)		
			6.00	7.00	8.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	4,596,378	52,694,137	0.087228		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,916,123	5,689,284	0.512564		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,854,307	66,516,452	0.072979		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	5,429,303	39,018,603	0.139147		55.00
60.00	06000	LABORATORY	4,470,235	40,288,271	0.110956		60.00
64.00	06400	INTRAVENOUS THERAPY	1,549,366	12,524,228	0.123710		64.00
65.00	06500	RESPIRATORY THERAPY	2,746,058	8,809,308	0.311722		65.00
66.00	06600	PHYSICAL THERAPY	3,434,914	12,969,374	0.264848		66.00
67.00	06700	OCCUPATIONAL THERAPY	772,037	2,162,671	0.356983		67.00
68.00	06800	SPEECH PATHOLOGY	58,856	311,856	0.188728		68.00
69.00	06900	ELECTROCARDIOLOGY	690,367	16,686,687	0.041372		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	325,632	1,963,054	0.165880		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,813,801	32,875,486	0.116007		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	13,499,203	38,868,522	0.347304		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	25,361,752	124,558,646	0.203613		73.00
74.00	07400	RENAL DIALYSIS	0	0	0.000000		74.00
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0.000000		77.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	254,120	123,863	2.051622		90.00
90.01	09001	WOUND CARE INSTITUTE	12,774	15,303	0.834738		90.01
90.02	09002	OP NUTRITIONAL COUNSELING	80,225	67,994	1.179884		90.02
91.00	09100	EMERGENCY	11,456,550	112,916,019	0.101461		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	3,018,408	8,794,308	0.343223		92.00
		OTHER REIMBURSABLE COST CENTERS					
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0.000000		102.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (sum of lines 50 thru 199)	89,340,409	577,854,066			200.00
201.00		Less Observation Beds	3,018,408	0			201.00
202.00		Total (line 200 minus line 201)	86,322,001	577,854,066			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-0057 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part I Date/Time Prepared: 5/29/2023 3:28 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)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,393,067	0	1,393,067	7,762	179.47	30.00
34.00	SURGICAL INTENSIVE CARE UNIT	317,221		317,221	1,478	214.63	34.00
43.00	NURSERY	10,142		10,142	584	17.37	43.00
200.00	Total (lines 30 through 199)	1,720,430		1,720,430	9,824		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6.00	7.00				
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,986	356,427				30.00
34.00	SURGICAL INTENSIVE CARE UNIT	492	105,598				34.00
43.00	NURSERY	0	0				43.00
200.00	Total (lines 30 through 199)	2,478	462,025				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-0057 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part II Date/Time Prepared: 5/29/2023 3:28 pm

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		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	802,354	52,694,137	0.015227	7,511,044	114,371	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	6,583	5,689,284	0.001157	13,232	15	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	312,666	66,516,452	0.004701	2,185,368	10,273	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	249,354	39,018,603	0.006391	138,117	883	55.00
60.00	06000	LABORATORY	145,138	40,288,271	0.003602	3,280,119	11,815	60.00
64.00	06400	INTRAVENOUS THERAPY	2,701	12,524,228	0.000216	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	89,305	8,809,308	0.010138	1,222,322	12,392	65.00
66.00	06600	PHYSICAL THERAPY	257,201	12,969,374	0.019831	958,248	19,003	66.00
67.00	06700	OCCUPATIONAL THERAPY	144,792	2,162,671	0.066951	92,770	6,211	67.00
68.00	06800	SPEECH PATHOLOGY	295	311,856	0.000946	51,530	49	68.00
69.00	06900	ELECTROCARDIOLOGY	36,386	16,686,687	0.002181	574,774	1,254	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	109,461	1,963,054	0.055761	38,269	2,134	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	32,041	32,875,486	0.000975	4,481,231	4,369	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	68,327	38,868,522	0.001758	7,191,866	12,643	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	111,150	124,558,646	0.000892	2,918,088	2,603	73.00
74.00	07400	RENAL DIALYSIS	0	0	0.000000	0	0	74.00
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0.000000	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	94,594	123,863	0.763699	0	0	90.00
90.01	09001	WOUND CARE INSTITUTE	24	15,303	0.001568	0	0	90.01
90.02	09002	OP NUTRITIONAL COUNSELING	100	67,994	0.001471	0	0	90.02
91.00	09100	EMERGENCY	494,068	112,916,019	0.004376	4,533,449	19,838	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	318,204	8,794,308	0.036183	626,956	22,685	92.00
200.00		Total (lines 50 through 199)	3,274,744	577,854,066		35,817,383	240,538	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0057 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part III Date/Time Prepared: 5/29/2023 3:28 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	0	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	7,762	0.00	1,986	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT		0	1,478	0.00	492	34.00
43.00	04300	NURSERY		0	584	0.00	0	43.00
200.00		Total (lines 30 through 199)		0	9,824		2,478	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
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	34.00
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: 15-0057 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part IV Date/Time Prepared: 5/29/2023 3:28 pm

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		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO 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
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CARE INSTITUTE	0	0	0	0	0	90.01
90.02	09002	OP NUTRITIONAL COUNSELING	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0057 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part IV | Date/Time Prepared: 5/29/2023 3:28 pm

Title XVIII | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	52,694,137	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	5,689,284	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	66,516,452	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	39,018,603	0.000000	55.00
60.00	06000	LABORATORY	0	0	0	40,288,271	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	12,524,228	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	8,809,308	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	12,969,374	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	2,162,671	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	311,856	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	16,686,687	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	1,963,054	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	32,875,486	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	38,868,522	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	124,558,646	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0.000000	74.00
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0.000000	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	123,863	0.000000	90.00
90.01	09001	WOUND CARE INSTITUTE	0	0	0	15,303	0.000000	90.01
90.02	09002	OP NUTRITIONAL COUNSELING	0	0	0	67,994	0.000000	90.02
91.00	09100	EMERGENCY	0	0	0	112,916,019	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	8,794,308	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	577,854,066		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0057 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part IV | Date/Time Prepared: 5/29/2023 3:28 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	7,511,044	0	10,337,398	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	13,232	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	2,185,368	0	12,606,234	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	138,117	0	11,217,542	0	55.00
60.00	06000	LABORATORY	0.000000	3,280,119	0	1,369,982	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	3,026,629	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	1,222,322	0	1,185,399	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	958,248	0	464,733	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	92,770	0	36,042	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	51,530	0	1,828	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	574,774	0	1,404,069	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	38,269	0	661,925	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	4,481,231	0	5,144,406	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	7,191,866	0	8,730,774	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	2,918,088	0	39,663,836	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0.000000	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	266	0	90.00
90.01	09001	WOUND CARE INSTITUTE	0.000000	0	0	3,074	0	90.01
90.02	09002	OP NUTRITIONAL COUNSELING	0.000000	0	0	0	0	90.02
91.00	09100	EMERGENCY	0.000000	4,533,449	0	15,684,042	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	626,956	0	1,172,559	0	92.00
200.00		Total (lines 50 through 199)		35,817,383	0	112,710,738	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0057 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part V Date/Time Prepared: 5/29/2023 3:28 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.087228	10,337,398	0	0	901,711	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.512564	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.072979	12,606,234	0	0	919,990	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.139147	11,217,542	0	0	1,560,887	55.00
60.00	06000	LABORATORY	0.110956	1,369,982	0	0	152,008	60.00
64.00	06400	INTRAVENOUS THERAPY	0.123710	3,026,629	0	0	374,424	64.00
65.00	06500	RESPIRATORY THERAPY	0.311722	1,185,399	0	0	369,515	65.00
66.00	06600	PHYSICAL THERAPY	0.264848	464,733	0	0	123,084	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.356983	36,042	0	0	12,866	67.00
68.00	06800	SPEECH PATHOLOGY	0.188728	1,828	0	0	345	68.00
69.00	06900	ELECTROCARDIOLOGY	0.041372	1,404,069	0	0	58,089	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.165880	661,925	0	0	109,800	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.116007	5,144,406	112	0	596,787	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.347304	8,730,774	0	0	3,032,233	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.203613	39,663,836	15,204	1,927	8,076,073	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0.000000	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2.051622	266	0	0	546	90.00
90.01	09001	WOUND CARE INSTITUTE	0.834738	3,074	0	0	2,566	90.01
90.02	09002	OP NUTRITIONAL COUNSELING	1.179884	0	0	0	0	90.02
91.00	09100	EMERGENCY	0.101461	15,684,042	0	0	1,591,319	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.343223	1,172,559	0	0	402,449	92.00
200.00		Subtotal (see instructions)		112,710,738	15,316	1,927	18,284,692	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		112,710,738	15,316	1,927	18,284,692	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0057 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part V Date/Time Prepared: 5/29/2023 3:28 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0		55.00
60.00	06000	LABORATORY	0	0		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	13	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,096	392		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0		77.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
90.01	09001	WOUND CARE INSTITUTE	0	0		90.01
90.02	09002	OP NUTRITIONAL COUNSELING	0	0		90.02
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00		Subtotal (see instructions)	3,109	392		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	3,109	392		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-0057 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part I Date/Time Prepared: 5/29/2023 3:28 pm

Title XIX | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,393,067	0	1,393,067	7,762	179.47	30.00
34.00	SURGICAL INTENSIVE CARE UNIT	317,221		317,221	1,478	214.63	34.00
43.00	NURSERY	10,142		10,142	584	17.37	43.00
200.00	Total (lines 30 through 199)	1,720,430		1,720,430	9,824		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6.00	7.00				
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	34	6,102				30.00
34.00	SURGICAL INTENSIVE CARE UNIT	0	0				34.00
43.00	NURSERY	1	17				43.00
200.00	Total (lines 30 through 199)	35	6,119				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-0057 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part II Date/Time Prepared: 5/29/2023 3:28 pm

Title XIX | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	802,354	52,694,137	0.015227	200,911	3,059	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	6,583	5,689,284	0.001157	321,096	372	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	312,666	66,516,452	0.004701	65,437	308	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	249,354	39,018,603	0.006391	0	0	55.00
60.00	06000	LABORATORY	145,138	40,288,271	0.003602	190,568	686	60.00
64.00	06400	INTRAVENOUS THERAPY	2,701	12,524,228	0.000216	9,641	2	64.00
65.00	06500	RESPIRATORY THERAPY	89,305	8,809,308	0.010138	62,515	634	65.00
66.00	06600	PHYSICAL THERAPY	257,201	12,969,374	0.019831	12,634	251	66.00
67.00	06700	OCCUPATIONAL THERAPY	144,792	2,162,671	0.066951	2,167	145	67.00
68.00	06800	SPEECH PATHOLOGY	295	311,856	0.000946	13,735	13	68.00
69.00	06900	ELECTROCARDIOLOGY	36,386	16,686,687	0.002181	12,829	28	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	109,461	1,963,054	0.055761	207	12	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	32,041	32,875,486	0.000975	114,527	112	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	68,327	38,868,522	0.001758	90,301	159	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	111,150	124,558,646	0.000892	155,339	139	73.00
74.00	07400	RENAL DIALYSIS	0	0	0.000000	0	0	74.00
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0.000000	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	94,594	123,863	0.763699	1,392	1,063	90.00
90.01	09001	WOUND CARE INSTITUTE	24	15,303	0.001568	21	0	90.01
90.02	09002	OP NUTRITIONAL COUNSELING	100	67,994	0.001471	0	0	90.02
91.00	09100	EMERGENCY	494,068	112,916,019	0.004376	146,432	641	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	318,204	8,794,308	0.036183	6,280	227	92.00
200.00		Total (lines 50 through 199)	3,274,744	577,854,066		1,406,032	7,851	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0057 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part III Date/Time Prepared: 5/29/2023 3:28 pm

Title XIX | Hospital | PPS

		Cost Center Description	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	7,762	0.00	34	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT		0	1,478	0.00	0	34.00
43.00	04300	NURSERY		0	584	0.00	1	43.00
200.00		Total (lines 30 through 199)		0	9,824		35	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
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	34.00
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: 15-0057 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part IV Date/Time Prepared: 5/29/2023 3:28 pm

Title XIX | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO 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
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CARE INSTITUTE	0	0	0	0	0	90.01
90.02	09002	OP NUTRITIONAL COUNSELING	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0057 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part IV Date/Time Prepared: 5/29/2023 3:28 pm

Title XIX | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	52,694,137	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	5,689,284	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	66,516,452	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	39,018,603	0.000000	55.00
60.00	06000	LABORATORY	0	0	0	40,288,271	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	12,524,228	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	8,809,308	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	12,969,374	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	2,162,671	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	311,856	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	16,686,687	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	1,963,054	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	32,875,486	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	38,868,522	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	124,558,646	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0.000000	74.00
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0.000000	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	123,863	0.000000	90.00
90.01	09001	WOUND CARE INSTITUTE	0	0	0	15,303	0.000000	90.01
90.02	09002	OP NUTRITIONAL COUNSELING	0	0	0	67,994	0.000000	90.02
91.00	09100	EMERGENCY	0	0	0	112,916,019	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	8,794,308	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	577,854,066		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0057 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part IV | Date/Time Prepared: 5/29/2023 3:28 pm

Title XIX | Hospital | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	200,911	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	321,096	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	65,437	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	55.00
60.00	06000	LABORATORY	0.000000	190,568	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	9,641	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	62,515	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	12,634	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	2,167	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	13,735	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	12,829	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	207	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	114,527	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	90,301	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	155,339	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0.000000	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	1,392	0	0	0	90.00
90.01	09001	WOUND CARE INSTITUTE	0.000000	21	0	0	0	90.01
90.02	09002	OP NUTRITIONAL COUNSELING	0.000000	0	0	0	0	90.02
91.00	09100	EMERGENCY	0.000000	146,432	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	6,280	0	0	0	92.00
200.00		Total (lines 50 through 199)		1,406,032	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0057 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part V Date/Time Prepared: 5/29/2023 3:28 pm

Title XIX | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.087228	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.512564	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.072979	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.139147	0	0	0	0	55.00
60.00	06000	LABORATORY	0.110956	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.123710	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.311722	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.264848	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.356983	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.188728	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.041372	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.165880	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.116007	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.347304	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.203613	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0.000000	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2.051622	0	0	0	0	90.00
90.01	09001	WOUND CARE INSTITUTE	0.834738	0	0	0	0	90.01
90.02	09002	OP NUTRITIONAL COUNSELING	1.179884	0	0	0	0	90.02
91.00	09100	EMERGENCY	0.101461	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.343223	0	0	0	0	92.00
200.00		Subtotal (see instructions)		0	0	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	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0057 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part V Date/Time Prepared: 5/29/2023 3:28 pm

Title XIX | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0		55.00
60.00	06000	LABORATORY	0	0		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0		77.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
90.01	09001	WOUND CARE INSTITUTE	0	0		90.01
90.02	09002	OP NUTRITIONAL COUNSELING	0	0		90.02
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	0		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0057 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-1 | Date/Time Prepared: 5/29/2023 3:28 pm

Title XVIII | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	7,762	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	7,762	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)	5,989	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	1,986	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	13,214,274	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	13,214,274	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)	13,214,274	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)	1,702.43	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	3,381,026	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)	3,381,026	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0057 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-1 | Date/Time Prepared: 5/29/2023 3:28 pm

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	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT	4,797,348	1,478	3,245.84	492	1,596,953	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)	6,199,327	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)	11,177,306	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)	462,025	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	240,538	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	702,563	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	10,474,743	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
55.01	Permanent adjustment amount per discharge	0.00	55.01
55.02	Adjustment amount per discharge (contractor use only)	0.00	55.02
56.00	Target amount (line 54 x sum of lines 55, 55.01, and 55.02)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)	0.00	59.00
60.00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)	0.00	60.00
61.00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	1,773	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,702.43	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	3,018,408	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0057 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-1 | Date/Time Prepared: 5/29/2023 3:28 pm

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	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	1,393,067	13,214,274	0.105421	3,018,408	318,204	90.00
91.00	Nursing Program cost	0	13,214,274	0.000000	3,018,408	0	91.00
92.00	Allied health cost	0	13,214,274	0.000000	3,018,408	0	92.00
93.00	All other Medical Education	0	13,214,274	0.000000	3,018,408	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0057 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-1 | Date/Time Prepared: 5/29/2023 3:28 pm

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	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	7,762	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	7,762	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)	5,989	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	34	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)	584	15.00
16.00	Nursery days (title V or XIX only)	1	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	13,214,274	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	13,214,274	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)	13,214,274	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)	1,702.43	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	57,883	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)	57,883	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0057 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-1 | Date/Time Prepared: 5/29/2023 3:28 pm

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	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	861,424	584	1,475.04	1	1,475	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT	4,797,348	1,478	3,245.84	0	0	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)	332,148	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)	391,506	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)	6,119	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	7,851	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	13,970	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	377,536	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
55.01	Permanent adjustment amount per discharge	0.00	55.01
55.02	Adjustment amount per discharge (contractor use only)	0.00	55.02
56.00	Target amount (line 54 x sum of lines 55, 55.01, and 55.02)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)	0.00	59.00
60.00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)	0.00	60.00
61.00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	1,773	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,702.43	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	3,018,408	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0057 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-1 | Date/Time Prepared: 5/29/2023 3:28 pm

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	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	1,393,067	13,214,274	0.105421	3,018,408	318,204	90.00
91.00	Nursing Program cost	0	13,214,274	0.000000	3,018,408	0	91.00
92.00	Allied health cost	0	13,214,274	0.000000	3,018,408	0	92.00
93.00	All other Medical Education	0	13,214,274	0.000000	3,018,408	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0057 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-3 | Date/Time Prepared: 5/29/2023 3:28 pm

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		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		5,293,778		30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT		1,820,470		34.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.087228	7,511,044	655,173	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.512564	13,232	6,782	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.072979	2,185,368	159,486	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.139147	138,117	19,219	55.00
60.00	06000	LABORATORY	0.110956	3,280,119	363,949	60.00
64.00	06400	INTRAVENOUS THERAPY	0.123710	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.311722	1,222,322	381,025	65.00
66.00	06600	PHYSICAL THERAPY	0.264848	958,248	253,790	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.356983	92,770	33,117	67.00
68.00	06800	SPEECH PATHOLOGY	0.188728	51,530	9,725	68.00
69.00	06900	ELECTROCARDIOLOGY	0.041372	574,774	23,780	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.165880	38,269	6,348	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.116007	4,481,231	519,854	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.347304	7,191,866	2,497,764	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.203613	2,918,088	594,161	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	74.00
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0.000000	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	2.051622	0	0	90.00
90.01	09001	WOUND CARE INSTITUTE	0.834738	0	0	90.01
90.02	09002	OP NUTRITIONAL COUNSELING	1.179884	0	0	90.02
91.00	09100	EMERGENCY	0.101461	4,533,449	459,968	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.343223	626,956	215,186	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		35,817,383	6,199,327	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)		35,817,383		202.00

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		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		188,819		30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT		108,366		34.00
43.00	04300	NURSERY		123,029		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.087228	200,911	17,525	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.512564	321,096	164,582	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.072979	65,437	4,776	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.139147	0	0	55.00
60.00	06000	LABORATORY	0.110956	190,568	21,145	60.00
64.00	06400	INTRAVENOUS THERAPY	0.123710	9,641	1,193	64.00
65.00	06500	RESPIRATORY THERAPY	0.311722	62,515	19,487	65.00
66.00	06600	PHYSICAL THERAPY	0.264848	12,634	3,346	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.356983	2,167	774	67.00
68.00	06800	SPEECH PATHOLOGY	0.188728	13,735	2,592	68.00
69.00	06900	ELECTROCARDIOLOGY	0.041372	12,829	531	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.165880	207	34	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.116007	114,527	13,286	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.347304	90,301	31,362	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.203613	155,339	31,629	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	74.00
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0.000000	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	2.051622	1,392	2,856	90.00
90.01	09001	WOUND CARE INSTITUTE	0.834738	21	18	90.01
90.02	09002	OP NUTRITIONAL COUNSELING	1.179884	0	0	90.02
91.00	09100	EMERGENCY	0.101461	146,432	14,857	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.343223	6,280	2,155	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,406,032	332,148	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)		1,406,032		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0057	Period: From 01/01/2022 To 12/31/2022	Worksheet E Part A Date/Time Prepared: 5/29/2023 3:28 pm
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		1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		
1.00	DRG Amounts Other than Outlier Payments	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	5,613,889	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	2,160,606	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)	0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)	0	1.04
2.00	Outlier payments for discharges. (see instructions)		2.00
2.01	Outlier reconciliation amount	0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)	0	2.02
2.03	Outlier payments for discharges occurring prior to October 1 (see instructions)	79,677	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)	4,878	2.04
3.00	Managed Care Simulated Payments	0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	75.14	4.00
	Indirect Medical Education Adjustment		
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)	0.00	5.00
5.01	FTE cap adjustment for qualifing hospitals under §131 of the CAA 2021 (see instructions)	0.00	5.01
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)	0.00	6.00
6.26	Rural track program FTE cap limitation adjustment after the cap-building window closed under §127 of the CAA 2021 (see instructions)	0.00	6.26
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.	0.00	7.01
7.02	Adjustment (increase or decrease) to the hospital's rural track program FTE limitation(s) for rural track programs with a rural track for Medicare GME affiliated programs in accordance with 413.75(b) and 87 FR 49075 (August 10, 2022) (see instructions)	0.00	7.02
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.	0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)	0.00	8.02
8.21	The amount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (see instructions)	0.00	8.21
9.00	Sum of lines 5 and 5.01, plus line 6, plus lines 6.26 through 6.49, minus lines 7 and 7.01, plus or minus line 7.02, plus/minus line 8, plus lines 8.01 through 8.27 (see instructions)	0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.	0.00	11.00
12.00	Current year allowable FTE (see instructions)	0.00	12.00
13.00	Total allowable FTE count for the prior year.	0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.	0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.	0.00	15.00
16.00	Adjustment for residents in initial years of the program (see instructions)	0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure	0.00	17.00
18.00	Adjusted rolling average FTE count	0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)	0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.000000	21.00
22.00	IME payment adjustment (see instructions)	0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)	0	22.01
	Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA		
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).	0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)	0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)	0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)	0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)	0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)	0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)	0	28.01
29.00	Total IME payment (sum of lines 22 and 28)	0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	0	29.01
	Disproportionate Share Adjustment		
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	1.41	30.00
31.00	Percentage of Medicaid patient days (see instructions)	21.67	31.00
32.00	Sum of lines 30 and 31	23.08	32.00
33.00	Allowable disproportionate share percentage (see instructions)	8.26	33.00
34.00	Disproportionate share adjustment (see instructions)	160,544	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0057	Period: From 01/01/2022 To 12/31/2022	Worksheet E Part A Date/Time Prepared: 5/29/2023 3:28 pm
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		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	Uncompensated Care Payment Adjustment			
35.00	Total uncompensated care amount (see instructions)	7,192,008,710	6,874,403,459	35.00
35.01	Factor 3 (see instructions)	0.000266342	0.000251949	35.01
35.02	Hospital UCP, including supplemental UCP (If line 34 is zero, enter zero on this line) (see instructions)	1,915,533	1,731,996	35.02
35.03	Pro rata share of the hospital UCP, including supplemental UCP (see instructions)	1,432,713	436,558	35.03
36.00	Total UCP adjustment (sum of columns 1 and 2 on line 35.03)	1,869,271		36.00
	Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)			
40.00	Total Medicare discharges (see instructions)	0		40.00
41.00	Total ESRD Medicare discharges (see instructions)	0		41.00
41.01	Total ESRD Medicare covered and paid discharges (see instructions)	0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days (see instructions)	0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00
47.00	Subtotal (see instructions)	9,888,865		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	0		48.00

		Amount	
		1.00	
49.00	Total payment for inpatient operating costs (see instructions)	9,888,865	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	596,436	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)	0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).	0	52.00
53.00	Nursing and Allied Health Managed Care payment	0	53.00
54.00	Special add-on payments for new technologies	35,507	54.00
54.01	Islet isolation add-on payment	0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)	0	55.00
55.01	Cellular therapy acquisition cost (see instructions)	0	55.01
56.00	Cost of physicians' services in a teaching hospital (see intructions)	0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).	0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)	0	58.00
59.00	Total (sum of amounts on lines 49 through 58)	10,520,808	59.00
60.00	Primary payer payments	0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	10,520,808	61.00
62.00	Deductibles billed to program beneficiaries	883,232	62.00
63.00	Coinsurance billed to program beneficiaries	4,279	63.00
64.00	Allowable bad debts (see instructions)	53,624	64.00
65.00	Adjusted reimbursable bad debts (see instructions)	34,856	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	14,577	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	9,668,153	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)	0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)	0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	70.00
70.50	Rural Community Hospital Demonstration Project (§410A Demonstration) adjustment (see instructions)	0	70.50
70.75	N95 respirator payment adjustment amount (see instructions)	0	70.75
70.87	Demonstration payment adjustment amount before sequestration	0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)	0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)	0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)	0	70.91
70.92	Bundled Model 1 discount amount (see instructions)	0	70.92
70.93	HVBP payment adjustment amount (see instructions)	0	70.93
70.94	HRR adjustment amount (see instructions)	-1,130	70.94
70.95	Recovery of accelerated depreciation	0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0057	Period: From 01/01/2022 To 12/31/2022	Worksheet E Part A Date/Time Prepared: 5/29/2023 3:28 pm
	Title XVIII	Hospital	PPS

		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	2021	814,301	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	2022	332,523	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		10,813,847	71.00
71.01	Sequestration adjustment (see instructions)		136,255	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
71.03	Sequestration adjustment-PARHM or CHART pass-throughs			71.03
72.00	Interim payments		9,853,702	72.00
72.01	Interim payments-PARHM or CHART			72.01
73.00	Tentative settlement (for contractor use only)		0	73.00
73.01	Tentative settlement-PARHM or CHART (for contractor use only)			73.01
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		823,890	74.00
74.01	Balance due provider/program-PARHM or CHART (see instructions)			74.01
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		126,530	75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	HSP Bonus Payment Amount			
100.00	HSP bonus amount (see instructions)	0	0	100.00
	HVBP Adjustment for HSP Bonus Payment			
101.00	HVBP adjustment factor (see instructions)	0.0000000000	0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)	0	0	102.00
	HRR Adjustment for HSP Bonus Payment			
103.00	HRR adjustment factor (see instructions)	0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)	0	0	104.00
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
	Cost Reimbursement			
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201.00
202.00	Medicare discharges (see instructions)			202.00
203.00	Case-mix adjustment factor (see instructions)			203.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
204.00	Medicare target amount			204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)			205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			206.00
	Adjustment to Medicare Part A Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)			211.00
	Comparision of PPS versus Cost Reimbursement			
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			212.00
213.00	Low-volume adjustment (see instructions)			213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			218.00

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 15-0057 | Period: From 01/01/2022 To 12/31/2022 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 5/29/2023 3:28 pm

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		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	5,613,889	0	5,613,889		5,613,889	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	2,160,606	0		2,160,606	2,160,606	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00						2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	79,677	0	79,677		79,677	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	4,878	0		4,878	4,878	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	0	4.00
	Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0	9.01
	Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0826	0.0826	0.0826	0.0826		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	160,544	0	115,927	44,617	160,544	11.00
11.01	Uncompensated care payments	36.00	1,869,271	0	1,432,713	436,558	1,869,271	11.01
	Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	9,888,865	0	7,242,206	2,646,659	9,888,865	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	9,888,865	0	7,242,206	2,646,659	9,888,865	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	596,436	0	433,037	163,399	596,436	16.00

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 15-0057 | Period: From 01/01/2022 To 12/31/2022 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 5/29/2023 3:28 pm

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		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
17.00	Special add-on payments for new technologies	54.00	35,507	0	35,507	0	35,507	17.00
17.01	Net organ aquisition cost							17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			0	7,710,750	2,810,058	10,520,808	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	587,166	0	424,372	162,794	587,166	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	9,270	0	8,665	605	9,270	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	596,436	0	433,037	163,399	596,436	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.105606	0.118333		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			814,301		814,301	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				332,523	332,523	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 15-0057 | Period: From 01/01/2022 To 12/31/2022 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/29/2023 3:28 pm

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		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	5,613,889	5,613,889		5,613,889	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	2,160,606		2,160,606	2,160,606	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00					2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	79,677	79,677		79,677	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	4,878		4,878	4,878	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	4.00
	Indirect Medical Education Adjustment						
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA						
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
	Disproportionate Share Adjustment						
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0826	0.0826	0.0826		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	160,544	115,927	44,617	160,544	11.00
11.01	Uncompensated care payments	36.00	1,869,271	1,432,713	436,558	1,869,271	11.01
	Additional payment for high percentage of ESRD beneficiary discharges						
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	9,888,865	7,242,206	2,646,659	9,888,865	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	9,888,865	7,242,206	2,646,659	9,888,865	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	596,436	433,037	163,399	596,436	16.00
17.00	Special add-on payments for new technologies	54.00	35,507	35,507	0	35,507	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			7,710,750	2,810,058	10,520,808	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 15-0057 | Period: From 01/01/2022 To 12/31/2022 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/29/2023 3:28 pm

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		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	587,166	424,372	162,794	587,166	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	9,270	8,665	605	9,270	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	596,436	433,037	163,399	596,436	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	814,301	814,301		814,301	28.00
29.00	Low volume adjustment on or after October 1	70.97	332,523		332,523	332,523	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	0	0	0	0	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	-1,130	-1,130	0	-1,130	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	0	0	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0057	Period: From 01/01/2022 To 12/31/2022	Worksheet E Part B Date/Time Prepared: 5/29/2023 3:28 pm
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		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	3,501	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	18,284,692	2.00
3.00	OPPS payments	13,789,522	3.00
4.00	Outlier payment (see instructions)	54,424	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)	3,501	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	17,243	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)	17,243	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	17,243	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	13,742	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)	3,501	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)	13,843,946	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	22	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	2,295,611	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)	11,551,814	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)	11,551,814	30.00
31.00	Primary payer payments	889	31.00
32.00	Subtotal (line 30 minus line 31)	11,550,925	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)	153,119	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	99,527	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	48,120	36.00
37.00	Subtotal (see instructions)	11,650,452	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.75	N95 respirator payment adjustment amount (see instructions)	0	39.75
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	11,650,452	40.00
40.01	Sequestration adjustment (see instructions)	146,796	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
40.03	Sequestration adjustment-PARHM or CHART pass-throughs		40.03
41.00	Interim payments	11,530,128	41.00
41.01	Interim payments-PARHM or CHART		41.01
42.00	Tentative settlement (for contractors use only)	0	42.00
42.01	Tentative settlement-PARHM or CHART (for contractor use only)		42.01
43.00	Balance due provider/program (see instructions)	-26,472	43.00
43.01	Balance due provider/program-PARHM (see instructions)		43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0057	Period: From 01/01/2022 To 12/31/2022	Worksheet E Part B Date/Time Prepared: 5/29/2023 3:28 pm
	Title XVIII	Hospital	PPS

		1.00	
	MEDICARE PART B ANCILLARY COSTS		
200.00	Part B Combined Billed Days	0	200.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Provider CCN: 15-0057 | Period: From 01/01/2022 To 12/31/2022 | Worksheet E-1 Part I Date/Time Prepared: 5/29/2023 3:28 pm

Title XVIII | Hospital | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		9,813,258		11,399,444	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	12/31/2022	40,444	12/31/2022	130,684	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)		40,444		130,684	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)		9,853,702		11,530,128	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		823,890		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		26,472	6.02
7.00	Total Medicare program liability (see instructions)		10,677,592		11,503,656	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: 15-0057	Period: From 01/01/2022 To 12/31/2022	Worksheet E-1 Part II Date/Time Prepared: 5/29/2023 3:28 pm
	Title XVIII	Hospital	PPS

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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0057	Period: From 01/01/2022 To 12/31/2022	Worksheet E-3 Part VII Date/Time Prepared: 5/29/2023 3:28 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		0	2.00
3.00	Organ acquisition (certified transplant programs only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	0	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	0	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	420,214		8.00
9.00	Ancillary service charges	1,406,032	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	1,826,246	0	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	1,826,246	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	1,826,246	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	0	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	606,067	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	606,067	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)	606,067	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	606,067	0	31.00
32.00	Deductibles	6,170	0	32.00
33.00	Coinsurance	5,483	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	594,414	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	594,414	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	594,414	0	40.00
41.00	Interim payments	594,414	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

OUTLIER RECONCILIATION AT TENTATIVE SETTLEMENT	Provider CCN: 15-0057	Period: From 01/01/2022 To 12/31/2022	Worksheet E-5 Date/Time Prepared: 5/29/2023 3:28 pm
	Title XVIII		PPS

		1.00	
	TO BE COMPLETED BY CONTRACTOR		
1.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)	0	1.00
2.00	Capital outlier from Wkst. L, Pt. I, line 2	0	2.00
3.00	Operating outlier reconciliation adjustment amount (see instructions)	0	3.00
4.00	Capital outlier reconciliation adjustment amount (see instructions)	0	4.00
5.00	The rate used to calculate the time value of money (see instructions)	0.00	5.00
6.00	Time value of money for operating expenses (see instructions)	0	6.00
7.00	Time value of money for capital related expenses (see instructions)	0	7.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 15-0057 | Period: From 01/01/2022 To 12/31/2022 | Worksheet G | Date/Time Prepared: 5/29/2023 3:28 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	19,637,184	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	79,738,179	0	0	0	4.00
5.00	Other receivable	597,537	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-58,517,697	0	0	0	6.00
7.00	Inventory	3,312,791	0	0	0	7.00
8.00	Prepaid expenses	53,991	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	44,821,985	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	922,177	0	0	0	12.00
13.00	Land improvements	2,764,457	0	0	0	13.00
14.00	Accumulated depreciation	-1,891,153	0	0	0	14.00
15.00	Buildings	74,840,399	0	0	0	15.00
16.00	Accumulated depreciation	-30,632,539	0	0	0	16.00
17.00	Leasehold improvements	2,854,691	0	0	0	17.00
18.00	Accumulated depreciation	-2,093,602	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	91,573,514	0	0	0	23.00
24.00	Accumulated depreciation	-43,402,917	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	94,935,027	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	2,534,311	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	45,640	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	2,579,951	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	142,336,963	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	10,701,261	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,968,461	0	0	0	38.00
39.00	Payroll taxes payable	350,710	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	447,957	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	13,468,389	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	182,082	0	0	0	48.00
49.00	Other long term liabilities	1,255,466	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	1,437,548	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	14,905,937	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	127,431,026				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)	127,431,026	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	142,336,963	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-0057 | Period: From 01/01/2022 To 12/31/2022 | Worksheet G-1 | Date/Time Prepared: 5/29/2023 3:28 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		75,869,132		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		51,187,893				2.00
3.00	Total (sum of line 1 and line 2)		127,057,025		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00	RECONCILIATION	374,002		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		374,002		0		10.00
11.00	Subtotal (line 3 plus line 10)		127,431,027		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		127,431,027		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	RECONCILIATION		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: 15-0057 | Period: From 01/01/2022 To 12/31/2022 | Worksheet G-2 Parts I & II Date/Time Prepared: 5/29/2023 3:28 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	16,880,528		16,880,528	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)	16,880,528		16,880,528	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT	5,870,900		5,870,900	14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	5,870,900		5,870,900	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	22,751,428		22,751,428	17.00
18.00	Ancillary services	84,796,595	356,469,573	441,266,168	18.00
19.00	Outpatient services	14,007,889	107,909,598	121,917,487	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER REVENUE	89,822	48,217,057	48,306,879	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	121,645,734	512,596,228	634,241,962	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		111,933,163		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)		111,933,163		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 15-0057	Period: From 01/01/2022 To 12/31/2022	Worksheet G-3 Date/Time Prepared: 5/29/2023 3:28 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	634,241,962	1.00
2.00	Less contractual allowances and discounts on patients' accounts	481,667,683	2.00
3.00	Net patient revenues (line 1 minus line 2)	152,574,279	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	111,933,163	4.00
5.00	Net income from service to patients (line 3 minus line 4)	40,641,116	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	45,156	6.00
7.00	Income from investments	4,198,167	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	417,410	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	261,058	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	8,467	21.00
22.00	Rental of hospital space	1,698,753	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER OPERATING REVENUE	3,917,766	24.00
24.01	OTHER (SPECIFY)	0	24.01
24.02	OTHER (SPECIFY)	0	24.02
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	10,546,777	25.00
26.00	Total (line 5 plus line 25)	51,187,893	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)	51,187,893	29.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 15-0057	Period: From 01/01/2022 To 12/31/2022	Worksheet L Parts I-III Date/Time Prepared: 5/29/2023 3:28 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	587,166	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	9,270	2.00
2.01	Model 4 BPCI Capital DRG outlier payments	0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)	20.80	3.00
4.00	Number of interns & residents (see instructions)	0.00	4.00
5.00	Indirect medical education percentage (see instructions)	0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)	0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	0.00	8.00
9.00	Sum of lines 7 and 8	0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)	0.00	10.00
11.00	Disproportionate share adjustment (see instructions)	0	11.00
12.00	Total prospective capital payments (see instructions)	596,436	12.00
		1.00	
	PART II - PAYMENT UNDER REASONABLE COST		
1.00	Program inpatient routine capital cost (see instructions)	0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)	0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)	0	3.00
4.00	Capital cost payment factor (see instructions)	0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)	0	5.00
		1.00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS		
1.00	Program inpatient capital costs (see instructions)	0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)	0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)	0	3.00
4.00	Applicable exception percentage (see instructions)	0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)	0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)	0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)	0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)	0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)	0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)	0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)	0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)	0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)	0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)	0	14.00
15.00	Current year allowable operating and capital payment (see instructions)	0	15.00
16.00	Current year operating and capital costs (see instructions)	0	16.00
17.00	Current year exception offset amount (see instructions)	0	17.00