

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: 15-0042	Period: From 01/01/2022 To 12/31/2022	Worksheet S Parts I-III Date/Time Prepared: 5/24/2023 12:05 pm
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PART I - COST REPORT STATUS			
Provider use only	1. <input checked="" type="checkbox"/> Electronically prepared cost report	Date: 5/24/2023	Time: 12:05 pm
	2. <input type="checkbox"/> Manually prepared cost report		
	3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no.		
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION BY A CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OR PROVIDER(S)
MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by GOOD SAMARI TAN HOSPITAL (15-0042) 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	Matthew Shuckman	Y	I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification to be the legally binding equivalent of my original signature.	
2	Signatory Printed Name		Matthew Shuckman	2
3	Signatory Title		CFO	3
4	Date		(Dated when report is electronically signed)	4

	Title V	Title XVIII		HIT	Title XIX	
		Part A	Part B			
	1.00	2.00	3.00	4.00	5.00	
PART III - SETTLEMENT SUMMARY						
1.00	HOSPITAL	0	2,104,737	500,341	0	159,523 1.00
2.00	SUBPROVIDER - I PF	0	34,829	988		-42,353 2.00
3.00	SUBPROVIDER - I RF	0	-38,671	35		885 3.00
5.00	SWING BED - SNF	0	0	0		0 5.00
6.00	SWING BED - NF	0				0 6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0 9.00
200.00	TOTAL	0	2,100,895	501,364	0	118,055 200.00

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: 15-0042	Period: From 01/01/2022 To 12/31/2022	Worksheet S-2 Part I Date/Time Prepared: 5/24/2023 12:05 pm
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1.00	2.00	3.00	4.00	1.00
Hospital and Hospital Health Care Complex Address:				
Street: 520 SOUTH 7TH STREET		PO Box:	Zip Code: 47591	County: KNOX
2.00	City: VINCENNES	State: IN		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	GOOD SAMARITAN HOSPITAL	150042	99915	1	07/01/1966	N	P	0	3.00
4.00	Subprovider - IPF	GOOD SAMARITAN HOSPITAL	15S042	99915	4	01/01/1984	N	P	0	4.00
5.00	Subprovider - IRF	GOOD SAMARITAN - REHAB	15T042	99915	5	01/01/2001	N	P	0	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	GOOD SAMARITAN HOME CENTER	157432	99915		06/27/1995	N	P	N	12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital -Based Hospice	GOOD SAMARITAN LINCOLN TRAIL HOSPICE	151526	99915		01/01/1984				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)				9				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	N				22.01
22.02	Is this a newly merged hospital that requires a final UCP to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.				N	N				22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)				N	N		N		22.03
22.04	Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.									22.04
22.04	Did this hospital receive a geographic reclassification from urban to rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)									22.04
22.04	Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.									22.04
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.				2	N				23.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0042			Period: From 01/01/2022 To 12/31/2022		Worksheet S-2 Part I Date/Time Prepared: 5/24/2023 12:05 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.	270	820	278	199	1,527	0		24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	27	52	0	99	51			25.00
						Urban/Rural	S	Date of Geogr	
						1.00		2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.						2		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.						2		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.						0		35.00
						Beginning:	Ending:		
						1.00	2.00		
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.								36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.						1		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.					01/01/2022	12/31/2022		38.00
						Y/N	Y/N		
						1.00	2.00		
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					N	N		39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					Y	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 impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2.					Y	Y		56.00
57.00	For cost reporting periods beginning prior to December 27, 2020, if line 56, column 1, is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.77(e)(1)(iv) and (v), regardless of which month(s) of the cost report the residents were on duty, if the response to line 56 is "Y" for yes, enter "Y" for yes in column 1, do not complete column 2, and complete Worksheet E-4.					Y			57.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0042	Period: From 01/01/2022 To 12/31/2022	Worksheet S-2 Part I Date/Time Prepared: 5/24/2023 12:05 pm		
		V	XVIII	XIX		
		1.00	2.00	3.00		
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
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.	Y	Y			60.00
60.01	If line 60 is yes, complete columns 2 and 3 for each program. (see instructions)		23.01	1		60.01
		Y/N	IME	Direct GME	IME	Direct GME
		1.00	2.00	3.00	4.00	5.00
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)					61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)					61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)					61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).					61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)					61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)					61.06
		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0.00	0.00	61.20
						1.00
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: 15-0042

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

Worksheet S-2
Part I
Date/Time Prepared:
5/24/2023 12:05 pm

		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1 / (col. 1 + col. 2))			
		1.00	2.00	3.00			
64.00	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. 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
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1 / (col. 1 + col. 2))	
		1.00	2.00	3.00	4.00	5.00	
66.00	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010. 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	14.53	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)	INTERNAL MEDICINE	1400	0.00	21.04	0.000000	67.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0042	Period: From 01/01/2022 To 12/31/2022	Worksheet S-2 Part I Date/Time Prepared: 5/24/2023 12:05 pm	
			1.00		
68.00	Direct GME in Accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022) For a cost reporting period beginning prior to October 1, 2022, did you obtain permission from your MAC to apply the new DGME formula in accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022)?		N		68.00
			1.00	2.00	3.00
Inpatient Psychiatric Facility PPS					
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.		Y		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)		N	Y	4
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.		Y		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)		N	N	0
			1.00		
Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.		N		80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.		N		81.00
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.		N		85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.		N		86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.		N		87.00
			Approved for Permanent Adjustment (Y/N)	Number of Approved Permanent Adjustments	
			1.00	2.00	
88.00	Column 1: Is this hospital approved for a permanent adjustment to the TEFRA target amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete col. 2 and line 89. (see instructions) Column 2: Enter the number of approved permanent adjustments.				0
			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
			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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0042	Period: From 01/01/2022 To 12/31/2022	Worksheet S-2 Part I Date/Time Prepared: 5/24/2023 12:05 pm	
		V 1.00	XIX 2.00		
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. 1, 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. 1? 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. 1V, 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. 1, 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. 1 through 1V? 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 1.00	Occupational 2.00	Speech 3.00	Respiratory 4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N
				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	
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	
112.00	Did this hospital participate in the Pennsylvania Rural Health Model (PARHM) demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N			112.00
113.00	Did this hospital participate in the Community Health Access and Rural Transformation (CHART) model for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no.				113.00
Miscellaneous Cost Reporting Information					
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N			115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	Y			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.		1		118.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0042	Period: From 01/01/2022 To 12/31/2022	Worksheet S-2 Part I Date/Time Prepared: 5/24/2023 12:05 pm	
		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	483,019	0	0	
		1.00	2.00		
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.		N	118.02	
119.00	DO NOT USE THIS LINE			119.00	
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.		N	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	5.00	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)		N		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:	Contractor's Name:	Contractor's Number:		141.00
142.00	Street:	PO Box:			142.00
143.00	City:	State:	Zip Code:		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: 15-0042		Period: From 01/01/2022 To 12/31/2022		Worksheet S-2 Part I Date/Time Prepared: 5/24/2023 12:05 pm			
								1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.							N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.							N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.							N	149.00
		Part A	Part B	Title V	Title XIX				
		1.00	2.00	3.00	4.00				
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)									
155.00	Hospital	N	N	N	N		N	155.00	
156.00	Subprovider - IPF	N	N	N	N		N	156.00	
157.00	Subprovider - IRF	N	N	N	N		N	157.00	
158.00	SUBPROVIDER							158.00	
159.00	SNF	N	N	N	N		N	159.00	
160.00	HOME HEALTH AGENCY	N	N	N	N		N	160.00	
161.00	CMHC		N	N	N		N	161.00	
								1.00	
Multi campus									
165.00	Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.							N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus		
		0	1.00	2.00	3.00	4.00	5.00		
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)							0.00	166.00
								1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act									
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.							Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)								168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)								168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)							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. 1, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)							N	0171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-0042		Period: From 01/01/2022 To 12/31/2022		Worksheet S-2 Part II Date/Time Prepared: 5/24/2023 12:05 pm	
				Y/N	Date		
				1.00	2.00		
PART II - HOSPITAL AND HOSPITAL HEALTHCARE COMPLEX REIMBURSEMENT QUESTIONNAIRE							
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.							
COMPLETED BY ALL HOSPITALS							
Provider Organization and Operation							
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N					1.00
				Y/N	Date	V/I	
				1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N					2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N					3.00
				Y/N	Type	Date	
				1.00	2.00	3.00	
Financial Data and Reports							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y		A			4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N					5.00
				Y/N	Legal Oper.		
				1.00	2.00		
Approved Educational Activities							
6.00	Column 1: Are costs claimed for a nursing program? Column 2: If yes, is the provider the legal operator of the program?	N					6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	Y					7.00
8.00	Were nursing programs and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N					8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	Y					9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	Y					10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N					11.00
				Y/N			
				1.00			
Bad Debts							
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y			12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N			13.00
14.00	If line 12 is yes, were patient deductibles and/or coinsurance amounts waived? If yes, see instructions.			N			14.00
Bed Complement							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N			15.00
				Part A		Part B	
				Y/N	Date	Y/N	Date
				1.00	2.00	3.00	4.00
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	02/17/2023	Y	02/17/2023		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N			17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N			19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-0042	Period: From 01/01/2022 To 12/31/2022	Worksheet S-2 Part II Date/Time Prepared: 5/24/2023 12:05 pm	
		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		N	N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions		N		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		N		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		Y		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		Y		25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		N		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		N		27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		N		28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions		N		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		N		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		N		31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		N		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				33.00
Provider-Based Physicians					
34.00	Were services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		Y		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		Y		35.00
			Y/N	Date	
			1.00	2.00	
Home Office Costs					
36.00	Were home office costs claimed on the cost report?		N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.				37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.				38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.				39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.				40.00
		1.00		2.00	
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	KYLE		SMITH	41.00
42.00	Enter the employer/company name of the cost report preparer.	BLUE & CO, LLC			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-713-7957		KCSMITH@BLUEANDCO.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 15-0042

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

Worksheet S-2
Part II
Date/Time Prepared:
5/24/2023 12:05 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.	DI RECTOR	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: 15-0042

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

Worksheet S-3
Part I
Date/Time Prepared:
5/24/2023 12:05 pm

Component	Worksheet A Line No.	No. of Beds	Bed Days Avai lable	CAH Hours	I/P Days / O/P Vi s i t s / Tri ps		
					Ti tle 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	69	25,185	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)		69	25,185	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	30	10,950	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		99	36,135	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF	40.00	20	7,300		0	16.00
17.00	SUBPROVIDER - IRF	41.00	25	9,125		0	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	116.00	0	0			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)		144				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: 15-0042

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

Worksheet S-3
Part I
Date/Time Prepared:
5/24/2023 12:05 pm

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVII	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)	4,796	548	9,733		1.00
2.00	HMO and other (see instructions)	3,212	2,546			2.00
3.00	HMO IPF Subprovider	222	2,993			3.00
4.00	HMO IRF Subprovider	213	202			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)	4,796	548	9,733		7.00
8.00	INTENSIVE CARE UNIT	2,370	0	5,306		8.00
9.00	CORONARY CARE UNIT					9.00
10.00	BURN INTENSIVE CARE UNIT					10.00
11.00	SURGICAL INTENSIVE CARE UNIT					11.00
12.00	OTHER SPECIAL CARE (SPECIFY)					12.00
13.00	NURSERY		0	818		13.00
14.00	Total (see instructions)	7,166	548	15,857	32.00	1,393.13
15.00	CAH visits	0	0	0		15.00
16.00	SUBPROVIDER - IPF	600	214	4,252	3.57	29.43
17.00	SUBPROVIDER - IRF	4,655	27	6,032	0.00	29.60
18.00	SUBPROVIDER					18.00
19.00	SKILLED NURSING FACILITY					19.00
20.00	NURSING FACILITY					20.00
21.00	OTHER LONG TERM CARE					21.00
22.00	HOME HEALTH AGENCY	0	0	0	0.00	0.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)					23.00
24.00	HOSPICE	0	0	0	0.00	7.84
24.10	HOSPICE (non-distinct part)			493		
25.00	CMHC - CMHC					25.00
26.00	RURAL HEALTH CLINIC					26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00
27.00	Total (sum of lines 14-26)				35.57	1,460.00
28.00	Observation Bed Days		6	2,698		28.00
29.00	Ambulance Trips	0				29.00
30.00	Employee discount days (see instruction)			0		30.00
31.00	Employee discount days - IRF			0		31.00
32.00	Labor & delivery days (see instructions)	0	0	885		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: 15-0042

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

Worksheet S-3
Part I
Date/Time Prepared:
5/24/2023 12:05 pm

Component	Full Time Equivalents	Discharges			Total All Patients		
		Nonpaid Workers	Title V	Title XVIII			Title XIX
		11.00	12.00	13.00			14.00
PART I - STATISTICAL DATA							
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	1,782	52	4,036	1.00
2.00	HMO and other (see instructions)			657	665		2.00
3.00	HMO IPF Subprovider				530		3.00
4.00	HMO IRF Subprovider				14		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	1,782	52	4,036	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF	0.00	0	88	50	817	16.00
17.00	SUBPROVIDER - IRF	0.00	0	317	2	424	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0.00					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: 15-0042

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

Worksheet S-3
Part II
Date/Time Prepared:
5/24/2023 12:05 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	106,970,890	0	106,970,890	2,991,499.00	35.76
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician and Non-Physician-Part B		8,890,152	0	8,890,152	39,827.00	223.22
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00
7.01	Contracted interns and residents (in an approved programs)		3,453,353	0	3,453,353	73,986.00	46.68
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00
9.00	SNF	44.00	0	0	0	0.00	0.00
10.00	Excluded area salaries (see instructions)		29,849,078	0	29,849,078	803,277.00	37.16
OTHER WAGES & RELATED COSTS							
11.00	Contract Labor: Direct Patient Care		3,831,032	0	3,831,032	77,673.00	49.32
12.00	Contract Labor: Top level management and other management and administrative services		0	0	0	0.00	0.00
13.00	Contract Labor: Physician-Part A - Administrative		681,225	0	681,225	5,622.00	121.17
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00
14.01	Home office salaries		0	0	0	0.00	0.00
14.02	Related organization salaries		0	0	0	0.00	0.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00
16.02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00
WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		19,267,996	0	19,267,996		
18.00	Wage-related costs (other) (see instructions)						
19.00	Excluded areas		7,487,649	0	7,487,649		
20.00	Non-physician anesthetist Part A		0	0	0		
21.00	Non-physician anesthetist Part B		0	0	0		
22.00	Physician Part A - Administrative		0	0	0		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		824,802	0	824,802		
24.00	Wage-related costs (RHC/FQHC)		0	0	0		
25.00	Interns & residents (in an approved program)		0	0	0		
25.50	Home office wage-related (core)		0	0	0		
25.51	Related organization wage-related (core)		0	0	0		
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0		

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0042

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

Worksheet S-3
Part II
Date/Time Prepared:
5/24/2023 12:05 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	6,037,561	0	6,037,561	281,849.00	21.42	26.00
27.00	Administrative & General	7,359,071	0	7,359,071	197,716.00	37.22	27.00
28.00	Administrative & General under contract (see inst.)	1,182,572	0	1,182,572	5,018.00	235.67	28.00
29.00	Maintenance & Repairs	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	2,349,223	0	2,349,223	91,547.00	25.66	30.00
31.00	Laundry & Linen Service	222,784	0	222,784	13,977.00	15.94	31.00
32.00	Housekeeping	2,112,199	0	2,112,199	117,179.00	18.03	32.00
33.00	Housekeeping under contract (see instructions)	0	0	0	0.00	0.00	33.00
34.00	Dietary	1,837,898	-1,276,604	561,294	25,150.00	22.32	34.00
35.00	Dietary under contract (see instructions)	1,962	0	1,962	25.00	78.48	35.00
36.00	Cafeteria	0	1,276,604	1,276,604	69,644.00	18.33	36.00
37.00	Maintenance of Personnel	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	1,864,857	0	1,864,857	44,150.00	42.24	38.00
39.00	Central Services and Supply	311,231	0	311,231	15,127.00	20.57	39.00
40.00	Pharmacy	2,950,603	0	2,950,603	68,390.00	43.14	40.00
41.00	Medical Records & Medical Records Library	3,662,513	0	3,662,513	119,690.00	30.60	41.00
42.00	Social Service	515,346	0	515,346	9,975.00	51.66	42.00
43.00	Other General Service	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0042

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

Worksheet S-3
Part III
Date/Time Prepared:
5/24/2023 12:05 pm

	Worksheet A Line Number	Amount Reported	Recl assi fi cat ion of Sal aries (from Worksheet A-6)	Adjusted Sal aries (col . 2 ± col . 3)	Paid Hours Related to Sal aries 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)	95,811,919	0	95,811,919	2,882,729.00	33.24	1.00
2.00	Excluded area salaries (see instructions)	29,849,078	0	29,849,078	803,277.00	37.16	2.00
3.00	Subtotal salaries (line 1 minus line 2)	65,962,841	0	65,962,841	2,079,452.00	31.72	3.00
4.00	Subtotal other wages & related costs (see inst.)	4,512,257	0	4,512,257	83,295.00	54.17	4.00
5.00	Subtotal wage-related costs (see inst.)	19,267,996	0	19,267,996	0.00	29.21	5.00
6.00	Total (sum of lines 3 thru 5)	89,743,094	0	89,743,094	2,162,747.00	41.49	6.00
7.00	Total overhead cost (see instructions)	30,407,820	0	30,407,820	1,059,437.00	28.70	7.00

HOSPITAL WAGE RELATED COSTS	Provider CCN: 15-0042	Period: From 01/01/2022 To 12/31/2022	Worksheet S-3 Part IV Date/Time Prepared: 5/24/2023 12:05 pm
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		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	4,609,380	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)			
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
HEALTH AND INSURANCE COST			
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	14,509,321	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	303,072	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	106,853	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)	236,592	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	441,721	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	7,219,751	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	48,927	22.00
23.00	Tuition Reimbursement	104,830	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	27,580,447	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: 15-0042	Period: From 01/01/2022 To 12/31/2022	Worksheet S-3 Part V Date/Time Prepared: 5/24/2023 12:05 pm
Cost Center Description		Contract Labor	Benefit Cost	
PART V - Contract Labor and Benefit Cost		1.00	2.00	
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	3,831,032	27,580,447	1.00
2.00	Hospital	3,831,032	27,580,447	2.00
3.00	SUBPROVIDER - IPF	0	0	3.00
4.00	SUBPROVIDER - IRF	0	0	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	0	0	11.00
12.00	AMBULATORY SURGICAL CENTER (D.P.) I			12.00
13.00	Hospital-Based Hospice	0	0	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			17.00
18.00	Other	0	0	18.00

HOSPITAL-BASED HOSPICE IDENTIFICATION DATA		Provider CCN: 15-0042 Hospice CCN: 15-1526	Period: From 01/01/2022 To 12/31/2022	Worksheet S-9 PARTS I THROUGH IV Date/Time Prepared: 5/24/2023 12:05 pm
		Hospice I		

	Unduplicated Days	Hospice I					Total (sum of cols. 1, 2 & 5)	
		Title XVIII	Title XIX	Title XVIII Skilled Nursing Facility	Title XIX Nursing Facility	All Other		
		1.00	2.00	3.00	4.00	5.00		
PART I - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING BEFORE OCTOBER 1, 2015								
1.00	Hospice Continuous Home Care							1.00
2.00	Hospice Routine Home Care							2.00
3.00	Hospice Inpatient Respite Care							3.00
4.00	Hospice General Inpatient Care							4.00
5.00	Total Hospice Days							5.00
Part II - CENSUS DATA FOR COST REPORTING PERIODS BEGINNING BEFORE OCTOBER 1, 2015								
6.00	Number of patients receiving hospice care							6.00
7.00	Total number of unduplicated Continuous Care hours billable to Medicare							7.00
8.00	Average Length of Stay (line 5 / line 6)							8.00
9.00	Unduplicated census count							9.00

NOTE: Parts I and II, columns 1 and 2 also include the days reported in columns 3 and 4.

		Title XVIII	Title XIX	Other	Total (sum of cols. 1 through 3)	
		1.00	2.00	3.00	4.00	
PART III - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015						
10.00	Hospice Continuous Home Care	0	0	0	0	10.00
11.00	Hospice Routine Home Care	6,666	0	0	6,666	11.00
12.00	Hospice Inpatient Respite Care	7	10	102	119	12.00
13.00	Hospice General Inpatient Care	333	0	0	333	13.00
14.00	Total Hospice Days	7,006	10	102	7,118	14.00
PART IV - CONTRACTED STATISTICAL DATA FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015						
15.00	Hospice Inpatient Respite Care	0	0	0	0	15.00
16.00	Hospice General Inpatient Care	0	0	0	0	16.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 15-0042	Period: From 01/01/2022 To 12/31/2022	Worksheet S-10 Date/Time Prepared: 5/24/2023 12:05 pm
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			1.00	
Uncompensated and indigent care cost computation				
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.265738	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid		15,893,360	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		Y	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid		0	5.00
6.00	Medicaid charges		94,923,024	6.00
7.00	Medicaid cost (line 1 times line 6)		25,224,655	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)		9,331,295	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)		9,331,295	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)	4,674,361	520,743	5,195,104
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	1,242,155	520,743	1,762,898
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0
23.00	Cost of charity care (line 21 minus line 22)	1,242,155	520,743	1,762,898
				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)		9,007,189	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		725,672	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		1,116,419	27.01
28.00	Non-Medicare bad debt expense (see instructions)		7,890,770	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		2,487,624	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		4,250,522	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		13,581,817	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES			Provider CCN: 15-0042		Period: From 01/01/2022 To 12/31/2022		Worksheet A	
Date/Time Prepared: 5/24/2023 12:05 pm								
Cost Center	Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassification (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)		
		1.00	2.00	3.00	4.00	5.00		
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT		16,106,665	16,106,665	6,073,889	22,180,554	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		460,319	460,319	0	460,319	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	676,011	1,760,531	2,436,542	25,619,274	28,055,816	4.00
4.01	00401	COMMUNICATIONS	296,862	103,642	400,504	-100,726	299,778	4.01
4.02	00402	PURCHASING & RECEIVING	747,817	668,173	1,415,990	-292,585	1,123,405	4.02
4.03	00403	REGISTRATION	1,664,815	641,958	2,306,773	-608,679	1,698,094	4.03
4.04	00404	PATIENT ACCOUNTS	2,652,056	2,585,849	5,237,905	-849,462	4,388,443	4.04
5.00	00500	ADMINISTRATIVE & GENERAL	7,359,071	25,691,635	33,050,706	-2,253,426	30,797,280	5.00
7.00	00700	OPERATION OF PLANT	2,349,223	5,720,324	8,069,547	-670,121	7,399,426	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	222,784	200,284	423,068	-100,098	322,970	8.00
9.00	00900	HOUSEKEEPING	2,112,199	960,977	3,073,176	-695,680	2,377,496	9.00
10.00	01000	DIETARY	1,837,898	1,915,862	3,753,760	-2,775,987	977,773	10.00
11.00	01100	CAFETERIA	0	0	0	2,223,842	2,223,842	11.00
13.00	01300	NURSING ADMINISTRATION	1,864,857	968,117	2,832,974	-354,911	2,478,063	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	311,231	284,444	595,675	-108,804	486,871	14.00
15.00	01500	PHARMACY	2,950,603	20,433,071	23,383,674	-20,228,351	3,155,323	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,662,513	1,516,990	5,179,503	-1,050,544	4,128,959	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
17.01	01701	MENTAL HEALTH OH	515,346	488,004	1,003,350	-149,084	854,266	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	3,453,353	3,453,353	38,103	3,491,456	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	1,977,325	691,596	2,668,921	-282,226	2,386,695	22.00
23.00	02300	PARAMED ED PRGM-RADIOLOGY	0	0	0	0	0	23.00
23.01	02301	PARAMED ED PRGM-LAB	210,226	53,815	264,041	-37,408	226,633	23.01
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	4,568,620	8,647,039	13,215,659	-765,090	12,450,569	30.00
31.00	03100	INTENSIVE CARE UNIT	2,999,237	3,032,453	6,031,690	-673,956	5,357,734	31.00
40.00	04000	SUBPROVIDER - IPF	1,811,804	545,281	2,357,085	-356,844	2,000,241	40.00
41.00	04100	SUBPROVIDER - IRF	1,977,908	741,002	2,718,910	-445,731	2,273,179	41.00
43.00	04300	NURSERY	434,565	111,030	545,595	-80,480	465,115	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	3,348,366	6,206,923	9,555,289	-3,406,259	6,149,030	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
51.01	05101	ENDOSCOPY	782,117	1,131,800	1,913,917	-377,389	1,536,528	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,289,619	286,470	1,576,089	-426,330	1,149,759	52.00
53.00	05300	ANESTHESIOLOGY	2,831,501	630,526	3,462,027	-474,440	2,987,587	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,582,047	5,031,520	9,613,567	-1,835,745	7,777,822	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	3,494,466	2,255,956	5,750,422	-723,504	5,026,918	55.00
60.00	06000	LABORATORY	2,202,773	6,620,609	8,823,382	-502,471	8,320,911	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	2,474,867	2,661,854	5,136,721	-904,947	4,231,774	65.00
66.00	06600	PHYSICAL THERAPY	6,098,289	1,698,671	7,796,960	-1,390,068	6,406,892	66.00
69.00	06900	ELECTROCARDIOLOGY	4,212,839	2,988,510	7,201,349	-2,003,131	5,198,218	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	746,643	1,196,290	1,942,933	-142,162	1,800,771	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	3,122,000	3,122,000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	3,981,786	3,981,786	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	19,415,326	19,415,326	73.00
75.00	07500	ASC (NON-DISTINCT PART)	1,042,332	2,211,657	3,253,989	-1,479,690	1,774,299	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	0	352,629	352,629	-799	351,830	76.01
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	101,920	20,324	122,244	-19,543	102,701	90.00
90.01	04950	WOUND CLINIC	368,555	1,292,414	1,660,969	-679,871	981,098	90.01
91.00	09100	EMERGENCY	4,246,569	3,431,036	7,677,605	-926,860	6,750,745	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	95,876	78,575	174,451	-16,874	157,577	96.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE	0	5,627,801	5,627,801	-5,627,801	0	113.00
116.00	11600	HOSPICE	513,668	614,997	1,128,665	-124,785	1,003,880	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	81,635,418	142,120,976	223,756,394	6,531,358	230,287,752	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	14,188,000	7,968,035	22,156,035	-3,399,256	18,756,779	192.00
192.01	19201	FP PETERSBURG	249,559	258,112	507,671	-56,715	450,956	192.01
192.02	19202	PEDIATRICS	1,029,933	388,931	1,418,864	-288,781	1,130,083	192.02
192.03	19203	WASHINGTON PRIMARY CARE	1,318,539	546,117	1,864,656	-332,705	1,531,951	192.03
192.04	19204	FQHC	1	248,915	248,916	-248,915	1	192.04

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-0042

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

Worksheet A

Date/Time Prepared:
5/24/2023 12:05 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	
194.00 07950 COMMUNITY HEALTH SERVICES	149,389	45,682	195,071	-37,384	157,687	194.00
194.01 07960 CCBHC GRANTS	2,033,632	1,793,442	3,827,074	-527,428	3,299,646	194.01
194.02 07952 MARKETING AND PUBLIC RELATIONS	240,743	589,268	830,011	-56,871	773,140	194.02
194.03 07953 MH RESIDENTIAL	484,868	171,552	656,420	-125,888	530,532	194.03
194.04 07954 UNUSED SPACE	0	0	0	0	0	194.04
194.05 07955 MOB	0	43,104	43,104	0	43,104	194.05
194.06 07956 FOUNDATION	0	0	0	0	0	194.06
194.07 07957 KNOX COUNTY HEALTH DEPT	0	0	0	0	0	194.07
194.08 07958 INDUSTRIAL HEALTH	0	0	0	0	0	194.08
194.09 07959 COMMUNITY MENTAL HEALTH CENTER	5,635,979	2,055,148	7,691,127	-1,455,943	6,235,184	194.09
194.10 07951 BEI RHAUS BUILDING	4,829	61,602	66,431	-1,472	64,959	194.10
200.00 TOTAL (SUM OF LINES 118 through 199)	106,970,890	156,290,884	263,261,774	0	263,261,774	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-0042

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

Worksheet A
Date/Time Prepared:
5/24/2023 12:05 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	-1,263,048	20,917,506	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	460,319	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-1,120	28,054,696	4.00
4.01	00401	COMMUNICATIONS	-84,929	214,849	4.01
4.02	00402	PURCHASING & RECEIVING	-241,227	882,178	4.02
4.03	00403	REGISTRATION	0	1,698,094	4.03
4.04	00404	PATIENT ACCOUNTS	-153,347	4,235,096	4.04
5.00	00500	ADMINISTRATIVE & GENERAL	-13,646,975	17,150,305	5.00
7.00	00700	OPERATION OF PLANT	-46,600	7,352,826	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	-2,945	320,025	8.00
9.00	00900	HOUSEKEEPING	-31,500	2,345,996	9.00
10.00	01000	DIETARY	0	977,773	10.00
11.00	01100	CAFETERIA	-1,029,936	1,193,906	11.00
13.00	01300	NURSING ADMINISTRATION	-127,535	2,350,528	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	486,871	14.00
15.00	01500	PHARMACY	0	3,155,323	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-47,987	4,080,972	16.00
17.00	01700	SOCIAL SERVICE	0	0	17.00
17.01	01701	MENTAL HEALTH OH	-6,062	848,204	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	3,491,456	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	165,000	2,551,695	22.00
23.00	02300	PARAMED ED PRGM-RADIOLOGY	0	0	23.00
23.01	02301	PARAMED ED PRGM-LAB	-27,167	199,466	23.01
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-3,581,685	8,868,884	30.00
31.00	03100	INTENSIVE CARE UNIT	0	5,357,734	31.00
40.00	04000	SUBPROVIDER - I PF	-10,900	1,989,341	40.00
41.00	04100	SUBPROVIDER - I RF	-110,510	2,162,669	41.00
43.00	04300	NURSERY	0	465,115	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-2,866,510	3,282,520	50.00
51.00	05100	RECOVERY ROOM	0	0	51.00
51.01	05101	ENDOSCOPY	-4,628	1,531,900	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,149,759	52.00
53.00	05300	ANESTHESIOLOGY	-2,380,869	606,718	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-1,358,443	6,419,379	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	-2,101,586	2,925,332	55.00
60.00	06000	LABORATORY	-173,109	8,147,802	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	-1,806,034	2,425,740	65.00
66.00	06600	PHYSICAL THERAPY	-2,048,815	4,358,077	66.00
69.00	06900	ELECTROCARDIOLOGY	-2,549,184	2,649,034	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	-745,324	1,055,447	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,122,000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	3,981,786	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-356,641	19,058,685	73.00
75.00	07500	ASC (NON-DISTINCT PART)	-91,265	1,683,034	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	-207,360	144,470	76.01
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	77.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	102,701	90.00
90.01	04950	WOUND CLINIC	-17,500	963,598	90.01
91.00	09100	EMERGENCY	-1,350,671	5,400,074	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	-484	157,093	96.00
101.00	10100	HOME HEALTH AGENCY	0	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	102.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
116.00	11600	HOSPICE	0	1,003,880	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-38,306,896	191,980,856	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	18,756,779	192.00
192.01	19201	FP PETERSBURG	0	450,956	192.01
192.02	19202	PEDIATRICS	0	1,130,083	192.02
192.03	19203	WASHINGTON PRIMARY CARE	0	1,531,951	192.03
192.04	19204	FOHC	0	1	192.04
194.00	07950	COMMUNITY HEALTH SERVICES	0	157,687	194.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-0042

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

Worksheet A
Date/Time Prepared:
5/24/2023 12:05 pm

Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation	
		6.00	7.00	
194.01	07960 CCBHC GRANTS	0	3,299,646	194.01
194.02	07952 MARKETING AND PUBLIC RELATIONS	0	773,140	194.02
194.03	07953 MH RESIDENTIAL	0	530,532	194.03
194.04	07954 UNUSED SPACE	0	0	194.04
194.05	07955 MOB	0	43,104	194.05
194.06	07956 FOUNDATION	0	0	194.06
194.07	07957 KNOX COUNTY HEALTH DEPT	0	0	194.07
194.08	07958 INDUSTRIAL HEALTH	0	0	194.08
194.09	07959 COMMUNITY MENTAL HEALTH CENTER	0	6,235,184	194.09
194.10	07951 BEI RHAUS BUILDING	0	64,959	194.10
200.00	TOTAL (SUM OF LINES 118 through 199)	-38,306,896	224,954,878	200.00

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
A - DRUGS CHARGED TO PATIENTS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	19,415,326	1.00
	O		0	19,415,326	
B - MEDICAL SUPPLIES CHARGED TO PATIENTS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	3,122,000	1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	3,981,786	2.00
3.00	DELIVERY ROOM & LABOR ROOM	52.00	0	104,844	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
26.00		0.00	0	0	26.00
	O		0	7,208,630	
C - EMPLOYEE BENEFITS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	25,660,749	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
26.00		0.00	0	0	26.00
27.00		0.00	0	0	27.00
28.00		0.00	0	0	28.00
29.00		0.00	0	0	29.00
30.00		0.00	0	0	30.00
31.00		0.00	0	0	31.00
32.00		0.00	0	0	32.00
33.00		0.00	0	0	33.00
34.00		0.00	0	0	34.00
35.00		0.00	0	0	35.00
36.00		0.00	0	0	36.00
37.00		0.00	0	0	37.00
38.00		0.00	0	0	38.00
39.00		0.00	0	0	39.00
40.00		0.00	0	0	40.00

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
41.00		0.00	0	0	41.00
42.00		0.00	0	0	42.00
43.00		0.00	0	0	43.00
44.00		0.00	0	0	44.00
45.00		0.00	0	0	45.00
46.00		0.00	0	0	46.00
47.00		0.00	0	0	47.00
48.00		0.00	0	0	48.00
49.00		0.00	0	0	49.00
			0	25,660,749	
D - INTEREST EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	5,627,801	1.00
			0	5,627,801	
E - INSURANCE EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	446,088	1.00
			0	446,088	
F - DIETARY RECLASS					
1.00	CAFETERIA	11.00	1,276,604	947,238	1.00
			1,276,604	947,238	
G - OB RECLASS					
1.00	ADULTS & PEDIATRICS	30.00	263,856	31,896	1.00
			263,856	31,896	
H - RESIDENT RECLASS					
1.00	I&R SERVICES-SALARY & FRINGES APPRVD	21.00		38,103	1.00
			0	38,103	
500.00	Grand Total: Increases		1,540,460	59,375,831	500.00

RECLASSIFICATIONS

Provider CCN: 15-0042

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

Worksheet A-6
Date/Time Prepared:
5/24/2023 12:05 pm

Decreases						Wkst. A-7 Ref.	
Cost Center	Line #	Salary	Other				
6.00	7.00	8.00	9.00	10.00			
A - DRUGS CHARGED TO PATIENTS							
1.00	PHARMACY	15.00	0	19,415,326	0		1.00
	O		0	19,415,326			
B - MEDICAL SUPPLIES CHARGED TO PATIENTS							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	41,475	0		1.00
2.00	PURCHASING & RECEIVING	4.02	0	67	0		2.00
3.00	ADMINISTRATIVE & GENERAL	5.00	0	212	0		3.00
4.00	OPERATION OF PLANT	7.00	0	2,211	0		4.00
5.00	HOUSEKEEPING	9.00	0	16	0		5.00
6.00	CENTRAL SERVICES & SUPPLY	14.00		81	0		6.00
7.00	PHARMACY	15.00		111,283	0		7.00
8.00	ADULTS & PEDIATRICS	30.00		80,317	0		8.00
9.00	INTENSIVE CARE UNIT	31.00		44,478	0		9.00
10.00	SUBPROVIDER - IPF	40.00		30	0		10.00
11.00	SUBPROVIDER - IRF	41.00		1,324	0		11.00
12.00	NURSERY	43.00		4,249	0		12.00
13.00	OPERATING ROOM	50.00		2,609,178	0		13.00
14.00	ENDOSCOPY	51.01		193,846	0		14.00
15.00	RADIOLOGY-DIAGNOSTIC	54.00		775,584	0		15.00
16.00	RADIOLOGY-THERAPEUTIC	55.00		7,943	0		16.00
17.00	LABORATORY	60.00		5,562	0		17.00
18.00	RESPIRATORY THERAPY	65.00		241,560	0		18.00
19.00	PHYSICAL THERAPY	66.00		117,620	0		19.00
20.00	ELECTROCARDIOLOGY	69.00		1,092,215	0		20.00
21.00	NEURODIAGNOSTICS	70.01		2,098	0		21.00
22.00	ASC (NON-DISTINCT PART)	75.00		1,182,353	0		22.00
23.00	INPATIENT DIALYSIS	76.01		799	0		23.00
24.00	CLINIC	90.00		266	0		24.00
25.00	WOUND CLINIC	90.01		611,518	0		25.00
26.00	EMERGENCY	91.00		82,345	0		26.00
	O		0	7,208,630			
C - EMPLOYEE BENEFITS							
1.00	COMMUNICATIONS	4.01	0	100,726	0		1.00
2.00	PURCHASING & RECEIVING	4.02	0	292,518	0		2.00
3.00	REGISTRATION	4.03	0	608,679	0		3.00
4.00	PATIENT ACCOUNTS	4.04	0	849,462	0		4.00
5.00	ADMINISTRATIVE & GENERAL	5.00	0	1,807,126	0		5.00
6.00	OPERATION OF PLANT	7.00	0	667,910	0		6.00
7.00	LAUNDRY & LINEN SERVICE	8.00	0	100,098	0		7.00
8.00	HOUSEKEEPING	9.00	0	695,664	0		8.00
9.00	DIETARY	10.00	0	552,145	0		9.00
10.00	NURSING ADMINISTRATION	13.00	0	354,911	0		10.00
11.00	CENTRAL SERVICES & SUPPLY	14.00	0	108,723	0		11.00
12.00	PHARMACY	15.00	0	701,742	0		12.00
13.00	MEDICAL RECORDS & LIBRARY	16.00	0	1,050,544	0		13.00
14.00	MENTAL HEALTH OH	17.01	0	149,084	0		14.00
15.00	I&R SERVICES-OTHER PRGM COSTS APPRVD	22.00	0	282,226	0		15.00
16.00	PARAMEDICAL PRGM-LAB	23.01	0	37,408	0		16.00
17.00	ADULTS & PEDIATRICS	30.00	0	980,525	0		17.00
18.00	INTENSIVE CARE UNIT	31.00	0	629,478	0		18.00
19.00	SUBPROVIDER - IPF	40.00	0	356,814	0		19.00
20.00	SUBPROVIDER - IRF	41.00	0	444,407	0		20.00
21.00	NURSERY	43.00	0	76,231	0		21.00
22.00	OPERATING ROOM	50.00	0	797,081	0		22.00
23.00	ENDOSCOPY	51.01	0	183,543	0		23.00
24.00	DELIVERY ROOM & LABOR ROOM	52.00	0	235,422	0		24.00
25.00	ANESTHESIOLOGY	53.00	0	474,440	0		25.00
26.00	RADIOLOGY-DIAGNOSTIC	54.00	0	1,060,161	0		26.00
27.00	RADIOLOGY-THERAPEUTIC	55.00	0	715,561	0		27.00
28.00	LABORATORY	60.00	0	496,909	0		28.00
29.00	RESPIRATORY THERAPY	65.00	0	663,387	0		29.00
30.00	PHYSICAL THERAPY	66.00	0	1,272,448	0		30.00
31.00	ELECTROCARDIOLOGY	69.00	0	910,916	0		31.00
32.00	NEURODIAGNOSTICS	70.01	0	140,064	0		32.00
33.00	ASC (NON-DISTINCT PART)	75.00	0	297,337	0		33.00
34.00	CLINIC	90.00	0	19,277	0		34.00
35.00	WOUND CLINIC	90.01	0	68,353	0		35.00
36.00	EMERGENCY	91.00	0	844,515	0		36.00
37.00	DURABLE MEDICAL EQUIP-RENTED	96.00	0	16,874	0		37.00
38.00	HOSPICE	116.00	0	124,785	0		38.00
39.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	3,399,256	0		39.00
40.00	FP PETERSBURG	192.01	0	56,715	0		40.00
41.00	PEDIATRICS	192.02	0	288,781	0		41.00

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
42.00	WASHINGTON PRIMARY CARE	192.03	0	332,705	0		42.00
43.00	FOHC	192.04	0	248,915	0		43.00
44.00	COMMUNITY HEALTH SERVICES	194.00	0	37,384	0		44.00
45.00	CCBHC GRANTS	194.01	0	527,428	0		45.00
46.00	MARKETING AND PUBLIC RELATIONS	194.02	0	56,871	0		46.00
47.00	MH RESIDENTIAL	194.03	0	125,888	0		47.00
48.00	COMMUNITY MENTAL HEALTH CENTER	194.09	0	1,417,840	0		48.00
49.00	BEIRHAUS BUILDING	194.10	0	1,472	0		49.00
			0	25,660,749			
D - INTEREST EXPENSE							
1.00	INTEREST EXPENSE	113.00	0	5,627,801	11		1.00
			0	5,627,801			
E - INSURANCE EXPENSE							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	446,088	12		1.00
			0	446,088			
F - DIETARY RECLASS							
1.00	DIETARY	10.00	1,276,604	947,238	0		1.00
			1,276,604	947,238			
G - OB RECLASS							
1.00	DELIVERY ROOM & LABOR ROOM	52.00	263,856	31,896	0		1.00
			263,856	31,896			
H - RESIDENT RECLASS							
1.00	COMMUNITY MENTAL HEALTH CENTER	194.09		38,103	0		1.00
	TOTALS		0	38,103			
500.00	Grand Total: Decreases		1,540,460	59,375,831			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0042

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

Worksheet A-7
Part I
Date/Time Prepared:
5/24/2023 12:05 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
			1.00	2.00	3.00		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	6,581,448	0	0	0	0	1.00
2.00	Land Improvements	10,726,598	0	0	0	0	2.00
3.00	Buildings and Fixtures	171,730,091	1,628,035	0	1,628,035	0	3.00
4.00	Building Improvements	515,426	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	224,603,323	5,283,866	0	5,283,866	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	414,156,886	6,911,901	0	6,911,901	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	414,156,886	6,911,901	0	6,911,901	0	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	6,581,448	0				1.00
2.00	Land Improvements	10,726,598	0				2.00
3.00	Buildings and Fixtures	173,358,126	0				3.00
4.00	Building Improvements	515,426	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	229,887,189	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	421,068,787	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	421,068,787	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0042

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

Worksheet A-7
Part II
Date/Time Prepared:
5/24/2023 12:05 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	16,106,665	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	460,319	0	0	2.00
3.00	Total (sum of lines 1-2)	16,106,665	0	460,319	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	16,106,665				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	460,319				2.00
3.00	Total (sum of lines 1-2)	0	16,566,984				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0042

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

Worksheet A-7
Part III
Date/Time Prepared:
5/24/2023 12:05 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	191,181,598	0	191,181,598	0.454039	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	229,887,189	0	229,887,189	0.545961	0	2.00
3.00	Total (sum of lines 1-2)	421,068,787	0	421,068,787	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	16,106,665	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	16,106,665	0	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	4,364,753	446,088	0	0	20,917,506	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	460,319	0	0	0	460,319	2.00
3.00	Total (sum of lines 1-2)	4,825,072	446,088	0	0	21,377,825	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 15-0042

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

Worksheet A-8

Date/Time Prepared:
5/24/2023 12:05 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
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-1,263,048	CAP REL COSTS-BLDG & FIXT	1.00	11	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)	B	-54,909	PURCHASING & RECEIVING	4.02	0	4.00
5.00 Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00 Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)	B	-44,294	OPERATION OF PLANT	7.00	0	7.00
8.00 Television and radio service (chapter 21)		0		0.00	0	8.00
9.00 Parking lot (chapter 21)		0		0.00	0	9.00
10.00 Provider-based physician adjustment	A-8-2	-20,528,968			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	0			0	12.00
13.00 Laundry and linen service		0		0.00	0	13.00
14.00 Cafeteria-employees and guests	B	-329,898	CAFETERIA	11.00	0	14.00
15.00 Rental of quarters to employees and others		0		0.00	0	15.00
16.00 Sale of medical and surgical supplies to other than patients	B	-356,641	DRUGS CHARGED TO PATIENTS	73.00	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
19.01 Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.01
19.02 Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.02
19.03 Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.03
20.00 Vending machines	B	-69,497	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

ADJUSTMENTS TO EXPENSES

Provider CCN: 15-0042

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

Worksheet A-8

Date/Time Prepared:
5/24/2023 12:05 pm

Line #	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
				3.00	4.00		
		1.00	2.00	5.00			
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	*** Cost Center Deleted ***	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	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	MISC INCOME	B	-1,120	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.00
33.01	MISC INCOME	B	-186,318	PURCHASING & RECEIVING	4.02	0	33.01
33.02	MISC INCOME	B	-1,023	PATIENT ACCOUNTS	4.04	0	33.02
33.03	MISC INCOME	B	-1,861,042	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04	MISC INCOME	B	-2,306	OPERATION OF PLANT	7.00	0	33.04
33.05	MISC INCOME	B	-2,945	LAUNDRY & LINEN SERVICE	8.00	0	33.05
33.06	MISC INCOME	B	-31,500	HOUSEKEEPING	9.00	0	33.06
33.07	MISC INCOME	B	-47,987	MEDICAL RECORDS & LIBRARY	16.00	0	33.07
33.09	MISC INCOME	B	-27,167	PARAMED PRGM-LAB	23.01	0	33.09
33.10	MISC INCOME	B	-10,900	SUBPROVIDER - IPF	40.00	0	33.10
33.11	MISC INCOME	B	-108,980	SUBPROVIDER - IRF	41.00	0	33.11
33.12	MISC INCOME	B	-28,907	OPERATING ROOM	50.00	0	33.12
33.13	MISC INCOME	B	-4,628	ENDOSCOPY	51.01	0	33.13
33.14	MISC INCOME	B	-510,055	RADIOLOGY-DIAGNOSTIC	54.00	0	33.14
33.15	MISC INCOME	B	-8,333	RADIOLOGY-THERAPEUTIC	55.00	0	33.15
33.16	MISC INCOME	B	-53,981	PHYSICAL THERAPY	66.00	0	33.16
33.17	MISC INCOME	B	-100,880	ELECTROCARDIOLOGY	69.00	0	33.17
33.18	MISC INCOME	B	-17,500	WOUND CLINIC	90.01	0	33.18
33.19	MISC INCOME	B	-1,000	EMERGENCY	91.00	0	33.19
33.20	MISC INCOME	B	-484	DURABLE MEDICAL EQUIP-RENTED	96.00	0	33.20
33.21	ADVERTISING	A	-1,724	ADMINISTRATIVE & GENERAL	5.00	0	33.21
33.22	ADVERTISING	A	-6,062	MENTAL HEALTH OH	17.01	0	33.22
33.23	ADVERTISING	A	-1,530	SUBPROVIDER - IRF	41.00	0	33.23
33.24	ADVERTISING	A	-651	RADIOLOGY-DIAGNOSTIC	54.00	0	33.24
33.25	ADVERTISING	A	-1,555	PHYSICAL THERAPY	66.00	0	33.25
33.26	ADVERTISING	A	-2,696	ELECTROCARDIOLOGY	69.00	0	33.26
33.27	PHYSICIAN BILLING COSTS	A	-152,324	PATIENT ACCOUNTS	4.04	0	33.27
33.28	2012 BOND ISSUE COSTS	A	45,855	ADMINISTRATIVE & GENERAL	5.00	0	33.28
33.29	GME CONSORTIUM FEES	A	200,000	I&R SERVICES-OTHER PRGM COSTS APPRVD	22.00	0	33.29
33.30	AHA LOBBYING OFFSET	A	-10,157	ADMINISTRATIVE & GENERAL	5.00	0	33.30
33.31	IHA LOBBYING OFFSET	A	-5,715	ADMINISTRATIVE & GENERAL	5.00	0	33.31
33.32	INDIANA CHAMBER LOBBYING OFFSET	A	-147	ADMINISTRATIVE & GENERAL	5.00	0	33.32
33.33	IHRA LOBBYING OFFSET	A	-1,000	ADMINISTRATIVE & GENERAL	5.00	0	33.33
33.34	PROVIDER ASSESSMENT FEE	A	-11,309,901	ADMINISTRATIVE & GENERAL	5.00	0	33.34
33.35	RENTAL	A	-166,429	ADMINISTRATIVE & GENERAL	5.00	0	33.35
33.36	RENTAL	A	-19,620	OPERATING ROOM	50.00	0	33.36
33.37	RENTAL	A	-3,000	ELECTROCARDIOLOGY	69.00	0	33.37
33.38	RENTAL	A	-207,360	INPATIENT DIALYSIS	76.01	0	33.38
33.39	PHYSICIAN LOAN EXPENSE	A	-70,998	ADMINISTRATIVE & GENERAL	5.00	0	33.39
33.40	PHYSICIAN LOAN EXPENSE	A	-35,000	I&R SERVICES-OTHER PRGM COSTS APPRVD	22.00	0	33.40
33.41	PHYSICIAN LOAN EXPENSE	A	-50,000	OPERATING ROOM	50.00	0	33.41
33.42	PHYSICIAN LOAN EXPENSE	A	-45,000	RADIOLOGY-THERAPEUTIC	55.00	0	33.42
33.43	PHYSICIAN LOAN EXPENSE	B	-5,000	ANESTHESIOLOGY	53.00	0	33.43
33.44	OTHER MISC FEES	B	-630,541	CAFETERIA	11.00	0	33.44
33.45	DONATIONS EXPENSE	B	-87,101	ADMINISTRATIVE & GENERAL	5.00	0	33.45
33.46	TELEPHONE OFFSET	A	-84,929	COMMUNICATIONS	4.01	0	33.46
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-38,306,896				50.00

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.
 (2) Basis for adjustment (see instructions).

Provider CCN: 15-0042	Period: From 01/01/2022 To 12/31/2022	Worksheet A-8 Date/Time Prepared: 5/24/2023 12:05 pm
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Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.
			Cost Center	Line #	
			1.00	2.00	

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.

PROVIDER BASED PHYSICIAN ADJUSTMENT			Provider CCN: 15-0042	Period: From 01/01/2022 To 12/31/2022	Worksheet A-8-2 Date/Time Prepared: 5/24/2023 12:05 pm
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1.00	2.00	3.00	4.00	5.00	6.00	7.00		
1.00	5.00	ADMI NI STRATI VE & GENERAL	384,524	96,399	288,125	211,500	2,025	1.00
2.00	13.00	NURSI NG ADMI NI STRATI ON	127,535	127,535	0	211,500	0	2.00
3.00	15.00	PHARMACY	12,275	0	12,275	211,500	157	3.00
4.00	30.00	ADULTS & PEDI ATRI CS	3,581,685	3,581,685	0	211,500	0	4.00
5.00	50.00	OPERATI NG ROOM	2,800,560	2,757,435	43,125	246,400	275	5.00
6.00	53.00	ANESTHESI OLOGY	2,375,869	2,375,869	0	246,400	0	6.00
7.00	54.00	RADI OLOGY-DI AGNOSTI C	847,737	847,737	0	271,900	0	7.00
8.00	55.00	RADI OLOGY-THERAPEUTI C	2,062,371	2,043,471	18,900	271,900	108	8.00
9.00	60.00	LABORATORY	307,776	173,109	134,667	260,300	1,276	9.00
10.00	65.00	RESPI RATORY THERAPY	1,827,484	1,806,034	21,450	211,500	272	10.00
11.00	66.00	PHYSI CAL THERAPY	1,993,279	1,993,279	0	211,500	0	11.00
12.00	69.00	ELECTROCARDI OLOGY	2,449,421	2,439,421	10,000	211,500	67	12.00
13.00	70.01	NEURODI AGNOSTI CS	753,560	732,110	21,450	211,500	81	13.00
14.00	75.00	ASC (NON-DI STI NCT PART)	120,550	81,250	39,300	211,500	288	14.00
15.00	76.01	INPATI ENT DI ALYSI S	40,560	0	40,560	211,500	672	15.00
16.00	91.00	EMERGENCY	1,390,446	1,339,073	51,373	211,500	401	16.00
200.00			21,075,632	20,394,407	681,225		5,622	200.00

1.00	2.00	8.00	9.00	12.00	13.00	14.00		
1.00	5.00	ADMI NI STRATI VE & GENERAL	205,908	10,295	0	0	0	1.00
2.00	13.00	NURSI NG ADMI NI STRATI ON	0	0	0	0	0	2.00
3.00	15.00	PHARMACY	15,964	798	0	0	0	3.00
4.00	30.00	ADULTS & PEDI ATRI CS	0	0	0	0	0	4.00
5.00	50.00	OPERATI NG ROOM	32,577	1,629	0	0	0	5.00
6.00	53.00	ANESTHESI OLOGY	0	0	0	0	0	6.00
7.00	54.00	RADI OLOGY-DI AGNOSTI C	0	0	0	0	0	7.00
8.00	55.00	RADI OLOGY-THERAPEUTI C	14,118	706	0	0	0	8.00
9.00	60.00	LABORATORY	159,684	7,984	0	0	0	9.00
10.00	65.00	RESPI RATORY THERAPY	27,658	1,383	0	0	0	10.00
11.00	66.00	PHYSI CAL THERAPY	0	0	0	0	0	11.00
12.00	69.00	ELECTROCARDI OLOGY	6,813	341	0	0	0	12.00
13.00	70.01	NEURODI AGNOSTI CS	8,236	412	0	0	0	13.00
14.00	75.00	ASC (NON-DI STI NCT PART)	29,285	1,464	0	0	0	14.00
15.00	76.01	INPATI ENT DI ALYSI S	68,331	3,417	0	0	0	15.00
16.00	91.00	EMERGENCY	40,775	2,039	0	0	0	16.00
200.00			609,349	30,468	0	0	0	200.00

1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.00	ADMI NI STRATI VE & GENERAL	0	205,908	82,217	178,616	1.00
2.00	13.00	NURSI NG ADMI NI STRATI ON	0	0	0	127,535	2.00
3.00	15.00	PHARMACY	0	15,964	0	0	3.00
4.00	30.00	ADULTS & PEDI ATRI CS	0	0	0	3,581,685	4.00
5.00	50.00	OPERATI NG ROOM	0	32,577	10,548	2,767,983	5.00
6.00	53.00	ANESTHESI OLOGY	0	0	0	2,375,869	6.00
7.00	54.00	RADI OLOGY-DI AGNOSTI C	0	0	0	847,737	7.00
8.00	55.00	RADI OLOGY-THERAPEUTI C	0	14,118	4,782	2,048,253	8.00
9.00	60.00	LABORATORY	0	159,684	0	173,109	9.00
10.00	65.00	RESPI RATORY THERAPY	0	27,658	0	1,806,034	10.00
11.00	66.00	PHYSI CAL THERAPY	0	0	0	1,993,279	11.00
12.00	69.00	ELECTROCARDI OLOGY	0	6,813	3,187	2,442,608	12.00
13.00	70.01	NEURODI AGNOSTI CS	0	8,236	13,214	745,324	13.00
14.00	75.00	ASC (NON-DI STI NCT PART)	0	29,285	10,015	91,265	14.00
15.00	76.01	INPATI ENT DI ALYSI S	0	68,331	0	0	15.00
16.00	91.00	EMERGENCY	0	40,775	10,598	1,349,671	16.00
200.00			0	609,349	134,561	20,528,968	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0042

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

Worksheet B
Part I
Date/Time Prepared:
5/24/2023 12:05 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	COMMUNICATIONS	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	4.01	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	20,917,506	20,917,506			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	460,319		460,319		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	28,054,696	114,982	2,530	28,172,208	4.00
4.01 00401	COMMUNICATIONS	214,849	0	0	78,680	4.01
4.02 00402	PURCHASING & RECEIVING	882,178	273,738	6,024	198,200	4.02
4.03 00403	REGISTRATION	1,698,094	267,329	5,883	441,239	4.03
4.04 00404	PATIENT ACCOUNTS	4,235,096	0	0	702,896	4.04
5.00 00500	ADMINISTRATIVE & GENERAL	17,150,305	1,134,350	24,963	1,950,433	5.00
7.00 00700	OPERATION OF PLANT	7,352,826	5,674,111	124,862	622,633	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	320,025	124,536	2,741	59,046	8.00
9.00 00900	HOUSEKEEPING	2,345,996	173,253	3,813	559,813	9.00
10.00 01000	DIETARY	977,773	90,410	1,990	148,764	10.00
11.00 01100	CAFETERIA	1,193,906	205,652	4,526	338,349	11.00
13.00 01300	NURSING ADMINISTRATION	2,350,528	230,886	5,081	494,258	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	486,871	93,816	2,065	82,488	14.00
15.00 01500	PHARMACY	3,155,323	141,398	3,112	782,022	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	4,080,972	108,313	2,384	970,705	16.00
17.00 01700	SOCIAL SERVICE	0	0	0	0	17.00
17.01 01701	MENTAL HEALTH OH	848,204	61,606	1,356	136,586	17.01
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	3,491,456	239,896	5,279	0	21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	2,551,695	0	0	524,066	22.00
23.00 02300	PARAMED ED PRGM-RADIOLOGY	0	0	0	0	23.00
23.01 02301	PARAMED ED PRGM-LAB	199,466	0	0	55,718	23.01
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	8,868,884	1,467,825	32,302	1,280,790	30.00
31.00 03100	INTENSIVE CARE UNIT	5,357,734	495,542	10,905	794,912	31.00
40.00 04000	SUBPROVIDER - I PF	1,989,341	308,242	6,783	480,197	40.00
41.00 04100	SUBPROVIDER - I RF	2,162,669	406,598	8,948	524,221	41.00
43.00 04300	NURSERY	465,115	0	0	115,176	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	3,282,520	568,192	12,504	887,444	50.00
51.00 05100	RECOVERY ROOM	0	0	0	0	51.00
51.01 05101	ENDOSCOPY	1,531,900	289,393	6,369	207,291	51.01
52.00 05200	DELIVERY ROOM & LABOR ROOM	1,149,759	0	0	271,866	52.00
53.00 05300	ANESTHESIOLOGY	606,718	0	0	750,455	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	6,419,379	512,380	11,276	1,214,417	54.00
55.00 05500	RADIOLOGY-THERAPEUTIC	2,925,332	425,328	9,360	926,166	55.00
60.00 06000	LABORATORY	8,147,802	172,591	3,798	583,819	60.00
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00
65.00 06500	RESPIRATORY THERAPY	2,425,740	134,303	2,956	655,934	65.00
66.00 06600	PHYSICAL THERAPY	4,358,077	670,356	14,752	1,616,278	66.00
69.00 06900	ELECTROCARDIOLOGY	2,649,034	429,963	9,462	1,116,562	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
70.01 07001	NEURODIAGNOSTICS	1,055,447	182,287	4,011	197,889	70.01
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,122,000	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	3,981,786	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	19,058,685	0	0	0	73.00
75.00 07500	ASC (NON-DISTINCT PART)	1,683,034	0	0	276,258	75.00
76.00 03950	MH ANCILLARY OUTPATIENT	0	0	0	0	76.00
76.01 03951	INPATIENT DIALYSIS	144,470	202,956	4,466	0	76.01
77.00 07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	77.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	102,701	53,305	1,173	27,013	90.00
90.01 04950	WOUND CLINIC	963,598	70,380	1,549	97,681	90.01
91.00 09100	EMERGENCY	5,400,074	559,749	12,318	1,125,502	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS						
96.00 09600	DURABLE MEDICAL EQUIP-RENTED	157,093	9,318	205	25,411	96.00
101.00 10100	HOME HEALTH AGENCY	0	0	0	0	101.00
102.00 10200	OPIOID TREATMENT PROGRAM	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
116.00 11600	HOSPICE	1,003,880	114,958	2,530	136,142	116.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	191,980,856	16,007,942	352,276	21,457,320	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	18,756,779	2,697,883	59,371	3,760,384	192.00
192.01 19201	FP PETERSBURG	450,956	87,620	1,928	66,143	192.01

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0042

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

Worksheet B
Part I
Date/Time Prepared:
5/24/2023 12:05 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	COMMUNICATIONS	
		BLDG & FIXT	MVBLE EQUIP			
		1.00	2.00			
	0	1.00	2.00	4.00	4.01	
192.02 19202 PEDIATRICS	1,130,083	0	0	272,971	2,601	192.02
192.03 19203 WASHINGTON PRIMARY CARE	1,531,951	160,813	3,539	349,463	0	192.03
192.04 19204 FOHC	1	0	0	0	0	192.04
194.00 07950 COMMUNITY HEALTH SERVICES	157,687	9,814	216	39,594	260	194.00
194.01 07960 CCBHC GRANTS	3,299,646	0	0	538,990	0	194.01
194.02 07952 MARKETING AND PUBLIC RELATIONS	773,140	39,967	880	63,806	650	194.02
194.03 07953 MH RESIDENTIAL	530,532	479,130	10,544	128,508	0	194.03
194.04 07954 UNUSED SPACE	0	481,731	10,601	0	0	194.04
194.05 07955 MOB	43,104	0	0	0	0	194.05
194.06 07956 FOUNDATION	0	11,020	243	0	390	194.06
194.07 07957 KNOX COUNTY HEALTH DEPT	0	111,434	2,452	0	0	194.07
194.08 07958 INDUSTRIAL HEALTH	0	0	0	0	0	194.08
194.09 07959 COMMUNITY MENTAL HEALTH CENTER	6,235,184	830,152	18,269	1,493,749	0	194.09
194.10 07951 BEIRHAUS BUILDING	64,959	0	0	1,280	0	194.10
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)	224,954,878	20,917,506	460,319	28,172,208	293,529	202.00

COST ALLOCATION - GENERAL SERVICE COSTS			Provider CCN: 15-0042	Period: From 01/01/2022 To 12/31/2022	Worksheet B Part I Date/Time Prepared: 5/24/2023 12:05 pm		
Cost Center Description			PURCHASING & RECEIVING	REGISTRATION	PATIENT ACCOUNTS	Subtotal	ADMINISTRATIVE & GENERAL
			4.02	4.03	4.04	4A.04	5.00
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
4.01	00401	COMMUNICATIONS					4.01
4.02	00402	PURCHASING & RECEIVING	1,362,741				4.02
4.03	00403	REGISTRATION	1,135	2,418,232			4.03
4.04	00404	PATIENT ACCOUNTS	895		4,944,609		4.04
5.00	00500	ADMINISTRATIVE & GENERAL	4,618	0	0	20,288,599	20,288,599
7.00	00700	OPERATION OF PLANT	12,565	0	0	13,802,603	1,368,252
8.00	00800	LAUNDRY & LINEN SERVICE	6,175	0	0	512,523	50,806
9.00	00900	HOUSEKEEPING	14,315	0	0	3,102,002	307,501
10.00	01000	DIETARY	29,241	0	0	1,249,218	123,835
11.00	01100	CAFETERIA	66,506	0	0	1,811,410	179,565
13.00	01300	NURSING ADMINISTRATION	1,303	0	0	3,084,527	305,769
14.00	01400	CENTRAL SERVICES & SUPPLY	5,503	0	0	671,653	66,581
15.00	01500	PHARMACY	2,151	0	0	4,088,038	405,247
16.00	01600	MEDICAL RECORDS & LIBRARY	439	0	0	5,168,925	512,396
17.00	01700	SOCIAL SERVICE	0	0	0	0	0
17.01	01701	MENTAL HEALTH OH	713	0	0	1,082,149	107,273
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	3,736,631	370,412
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	2,451	0	0	3,084,975	305,814
23.00	02300	PARAMED PRGM-RADIOLOGY	0	0	0	0	0
23.01	02301	PARAMED PRGM-LAB	110	0	0	255,294	25,307
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	24,872	107,448	219,705	12,023,285	1,191,868
31.00	03100	INTENSIVE CARE UNIT	21,605	62,036	126,848	6,882,067	682,219
40.00	04000	SUBPROVIDER - I PF	1,777	34,176	69,881	2,890,397	286,525
41.00	04100	SUBPROVIDER - I RF	6,335	29,593	60,510	3,208,368	318,046
43.00	04300	NURSERY	1,657	5,236	10,707	597,891	59,269
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	57,800	178,527	365,045	5,371,280	532,455
51.00	05100	RECOVERY ROOM	0	0	0	0	0
51.01	05101	ENDOSCOPY	45,280	42,945	87,812	2,214,371	219,511
52.00	05200	DELIVERY ROOM & LABOR ROOM	5,983	29,774	60,881	1,526,456	151,318
53.00	05300	ANESTHESIOLOGY	0	0	0	1,357,173	134,537
54.00	05400	RADIOLOGY-DIAGNOSTIC	36,159	372,649	761,887	9,339,852	925,860
55.00	05500	RADIOLOGY-THERAPEUTIC	6,086	91,648	187,398	4,576,000	453,619
60.00	06000	LABORATORY	132,320	274,823	561,947	9,881,522	979,555
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	1,701	54,519	111,478	3,391,703	336,220
66.00	06600	PHYSICAL THERAPY	4,353	96,872	198,080	6,966,571	690,596
69.00	06900	ELECTROCARDIOLOGY	10,810	182,113	372,377	4,780,725	473,913
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0
70.01	07001	NEURODIAGNOSTICS	2,311	24,926	50,967	1,520,439	150,721
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	449,449	7	14	3,571,470	354,040
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	281,451	0	0	4,263,237	422,615
73.00	07300	DRUGS CHARGED TO PATIENTS	0	256,990	525,483	19,841,158	1,966,854
75.00	07500	ASC (NON-DISTINCT PART)	24,945	94,967	194,185	2,273,389	225,361
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0	0	0
76.01	03951	INPATIENT DIALYSIS	73	3,740	7,648	363,743	36,058
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	26	327	669	186,515	18,489
90.01	04950	WOUND CLINIC	6,985	22,948	46,923	1,211,365	120,083
91.00	09100	EMERGENCY	26,826	189,584	387,653	7,714,841	764,772
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0	0
OTHER REIMBURSABLE COST CENTERS							
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	718	1,494	3,055	197,294	19,558
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	2,085	7,413	15,157	1,285,156	127,398
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,299,727	2,164,755	4,426,310	179,374,815	15,770,218
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	41,845	194,670	398,053	25,943,840	2,571,841
192.01	19201	FP PETERSBURG	131	2,061	4,214	613,053	60,772
192.02	19202	PEDIATRICS	2,003	10,520	21,511	1,439,689	142,716
192.03	19203	WASHINGTON PRIMARY CARE	1,672	11,574	23,666	2,082,678	206,456
192.04	19204	FOHC	0	263	537	801	79
194.00	07950	COMMUNITY HEALTH SERVICES	0	2,783	5,691	216,045	21,417
194.01	07960	CCBHC GRANTS	11,458	0	0	3,850,094	381,660

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0042

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

Worksheet B
Part I
Date/Time Prepared:
5/24/2023 12:05 pm

Cost Center Description		PURCHASING & RECEIVING	REGISTRATION	PATIENT ACCOUNTS	Subtotal	ADMINISTRATIVE & GENERAL		
		4.02	4.03	4.04	4A.04	5.00		
194.02	07952	MARKETING AND PUBLIC RELATIONS	31	614	1,256	880,344	87,269	194.02
194.03	07953	MH RESIDENTIAL	2,086	0	0	1,150,800	114,079	194.03
194.04	07954	UNUSED SPACE	0	0	0	492,332	48,805	194.04
194.05	07955	MOB	0	0	0	43,104	4,273	194.05
194.06	07956	FOUNDATION	0	0	0	11,653	1,155	194.06
194.07	07957	KNOX COUNTY HEALTH DEPT	0	0	0	113,886	11,290	194.07
194.08	07958	INDUSTRIAL HEALTH	0	0	0	0	0	194.08
194.09	07959	COMMUNITY MENTAL HEALTH CENTER	3,712	30,992	63,371	8,675,429	859,995	194.09
194.10	07951	BEIRHAUS BUILDING	76	0	0	66,315	6,574	194.10
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,362,741	2,418,232	4,944,609	224,954,878	20,288,599	202.00

COST ALLOCATION - GENERAL SERVICE COSTS			Provider CCN: 15-0042		Period: From 01/01/2022 To 12/31/2022		Worksheet B Part I Date/Time Prepared: 5/24/2023 12:05 pm	
Cost Center Description			OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401	COMMUNICATIONS						4.01
4.02	00402	PURCHASING & RECEIVING						4.02
4.03	00403	REGISTRATION						4.03
4.04	00404	PATIENT ACCOUNTS						4.04
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	15,170,855					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	140,438	703,767				8.00
9.00	00900	HOUSEKEEPING	195,376	33,875	3,638,754			9.00
10.00	01000	DIETARY	101,955	2,477	99,496	1,576,981		10.00
11.00	01100	CAFETERIA	231,913	5,633	24,845	0	2,253,366	11.00
13.00	01300	NURSING ADMINISTRATION	260,368	0	0	0	48,216	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	105,795	11,240	44,041	0	16,617	14.00
15.00	01500	PHARMACY	159,453	0	35,048	0	74,788	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	122,143	0	25,768	0	131,804	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
17.01	01701	MENTAL HEALTH OH	69,472	0	104,338	0	11,502	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	270,529	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	32,973	0	32,823	22.00
23.00	02300	PARAMED ED PRGM-RADIOLOGY	0	0	0	0	0	23.00
23.01	02301	PARAMED ED PRGM-LAB	0	0	0	0	6,035	23.01
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,655,257	247,609	874,136	714,768	161,617	30.00
31.00	03100	INTENSIVE CARE UNIT	558,820	45,366	223,376	293,451	86,269	31.00
40.00	04000	SUBPROVIDER - I PF	347,602	14,156	0	235,159	66,767	40.00
41.00	04100	SUBPROVIDER - I RF	458,518	35,871	152,703	333,603	67,161	41.00
43.00	04300	NURSERY	0	1,875	8,359	0	9,396	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	640,746	32,709	216,113	0	73,719	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
51.01	05101	ENDOSCOPY	326,347	20,826	58,049	0	26,579	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	8,223	10,607	0	32,102	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	18,110	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	577,808	44,310	121,459	0	121,748	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	479,640	6,984	64,563	0	68,699	55.00
60.00	06000	LABORATORY	194,629	0	55,513	0	99,023	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	151,453	360	42,196	0	67,759	65.00
66.00	06600	PHYSICAL THERAPY	755,956	7,691	102,782	0	152,621	66.00
69.00	06900	ELECTROCARDIOLOGY	484,867	21,058	164,520	0	85,643	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	205,564	8,195	28,880	0	20,461	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	20,743	166,134	0	39,847	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0	0	0	76.00
76.01	03951	INPATIENT DIAGNOSIS	228,872	0	0	0	0	76.01
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	60,112	84	62,891	0	3,427	90.00
90.01	04950	WOUND CLINIC	79,367	10,488	18,447	0	10,116	90.01
91.00	09100	EMERGENCY	631,226	94,607	247,126	0	128,069	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	10,508	0	0	0	3,923	96.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	129,637	0	49,517	0	17,776	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	9,634,371	674,380	3,033,880	1,576,981	1,682,617	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,042,385	29,387	582,046	0	336,133	192.00
192.01	19201	FP PETERSBURG	98,808	0	0	0	9,577	192.01
192.02	19202	PEDIATRICS	0	0	0	0	24,574	192.02
192.03	19203	WASHINGTON PRIMARY CARE	181,348	0	0	0	33,599	192.03
192.04	19204	FQHC	0	0	0	0	34,944	192.04
194.00	07950	COMMUNITY HEALTH SERVICES	11,068	0	19,081	0	5,041	194.00
194.01	07960	CCBHC GRANTS	0	0	1,672	0	90,467	194.01

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0042

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

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Cost Center Description		OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA		
		7.00	8.00	9.00	10.00	11.00		
194.02	07952	MARKETING AND PUBLIC RELATIONS	45,070	0	2,075	0	8,245	194.02
194.03	07953	MH RESIDENTIAL	540,311	0	0	0	28,169	194.03
194.04	07954	UNUSED SPACE	543,245	0	0	0	0	194.04
194.05	07955	MOB	0	0	0	0	0	194.05
194.06	07956	FOUNDATION	12,428	0	0	0	0	194.06
194.07	07957	KNOX COUNTY HEALTH DEPT	125,664	0	0	0	0	194.07
194.08	07958	INDUSTRIAL HEALTH	0	0	0	0	0	194.08
194.09	07959	COMMUNITY MENTAL HEALTH CENTER	936,157	0	0	0	0	194.09
194.10	07951	BEIRHAUS BUILDING	0	0	0	0	0	194.10
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	15,170,855	703,767	3,638,754	1,576,981	2,253,366	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0042

Period:
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Cost Center Description		NURSING ADMINISTRATIVE	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		13.00	14.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
4.01	00401						4.01
4.02	00402						4.02
4.03	00403						4.03
4.04	00404						4.04
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100						11.00
13.00	01300	3,698,880					13.00
14.00	01400		915,927				14.00
15.00	01500		1,614	4,764,188			15.00
16.00	01600		329		5,961,365		16.00
17.00	01700		0	0	0	0	17.00
17.01	01701		535	0	0	0	17.01
21.00	02100		0	0	0	0	21.00
22.00	02200	147,734	1,840	4,533	0	0	22.00
23.00	02300		0	0	0	0	23.00
23.01	02301		82	0	0	0	23.01
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	652,985	18,665	24	777,241	0	30.00
31.00	03100	388,295	16,213	0	679,143	0	31.00
40.00	04000	298,046	1,333	0	747,057	0	40.00
41.00	04100	302,292	4,754	0	528,222	0	41.00
43.00	04300	42,290	1,244	20	60,368	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	240,871	43,376	4,183	256,565	0	50.00
51.00	05100	0	0	0	0	0	51.00
51.01	05101	119,633	33,981	10,211	0	0	51.01
52.00	05200	181,653	4,490	76	0	0	52.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	55,457	27,136	24,824	0	0	54.00
55.00	05500	197,039	4,568	926	0	0	55.00
60.00	06000	0	99,301	6	0	0	60.00
63.00	06300	0	0	0	0	0	63.00
65.00	06500	0	1,276	275	0	0	65.00
66.00	06600	168,992	3,267	25,575	0	0	66.00
69.00	06900	0	8,112	12,821	0	0	69.00
70.00	07000	0	0	0	0	0	70.00
70.01	07001	15,204	1,734	10	0	0	70.01
71.00	07100	0	337,297	0	0	0	71.00
72.00	07200	0	211,218	0	0	0	72.00
73.00	07300	0	0	4,388,797	0	0	73.00
75.00	07500	179,351	18,721	3,610	1,637,490	0	75.00
76.00	03950	0	0	0	0	0	76.00
76.01	03951	0	55	180	0	0	76.01
77.00	07700	0	0	0	0	0	77.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	20	60	0	0	90.00
90.01	04950	10,138	5,242	3,645	75,460	0	90.01
91.00	09100	576,439	20,132	2,676	1,199,819	0	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
96.00	09600	0	539	0	0	0	96.00
101.00	10100	0	0	0	0	0	101.00
102.00	10200	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
116.00	11600	80,009	1,565	1,379	0	0	116.00
118.00							118.00
		3,656,428	868,639	4,483,831	5,961,365	0	
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	42,452	31,403	256,488	0	0	192.00
192.01	19201	0	98	4,926	0	0	192.01
192.02	19202	0	1,503	8,958	0	0	192.02
192.03	19203	0	1,255	9,736	0	0	192.03
192.04	19204	0	0	1	0	0	192.04
194.00	07950	0	0	248	0	0	194.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0042

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Cost Center Description		NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		13.00	14.00	15.00	16.00	17.00	
194.01	07960 CCBHC GRANTS	0	8,599	0	0	0	194.01
194.02	07952 MARKETING AND PUBLIC RELATIONS	0	23	0	0	0	194.02
194.03	07953 MH RESIDENTIAL	0	1,565	0	0	0	194.03
194.04	07954 UNUSED SPACE	0	0	0	0	0	194.04
194.05	07955 MOB	0	0	0	0	0	194.05
194.06	07956 FOUNDATION	0	0	0	0	0	194.06
194.07	07957 KNOX COUNTY HEALTH DEPT	0	0	0	0	0	194.07
194.08	07958 INDUSTRIAL HEALTH	0	0	0	0	0	194.08
194.09	07959 COMMUNITY MENTAL HEALTH CENTER	0	2,785	0	0	0	194.09
194.10	07951 BEIRHAUS BUILDING	0	57	0	0	0	194.10
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	3,698,880	915,927	4,764,188	5,961,365	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0042

Period:
From 01/01/2022
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Cost Center Description	INTERNS & RESIDENTS					17.01	21.00	22.00	23.00	23.01
	MENTAL HEALTH OH	SERVICES-SALARY & FRINGES	SERVICES-OTHER PRGM COSTS	PARAMED PRGM-RADIOLOGY	PARAMED PRGM-LAB					
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
4.01	00401	COMMUNICATIONS								4.01
4.02	00402	PURCHASING & RECEIVING								4.02
4.03	00403	REGISTRATION								4.03
4.04	00404	PATIENT ACCOUNTS								4.04
5.00	00500	ADMINISTRATIVE & GENERAL								5.00
7.00	00700	OPERATION OF PLANT								7.00
8.00	00800	LAUNDRY & LINEN SERVICE								8.00
9.00	00900	HOUSEKEEPING								9.00
10.00	01000	DIETARY								10.00
11.00	01100	CAFETERIA								11.00
13.00	01300	NURSING ADMINISTRATION								13.00
14.00	01400	CENTRAL SERVICES & SUPPLY								14.00
15.00	01500	PHARMACY								15.00
16.00	01600	MEDICAL RECORDS & LIBRARY								16.00
17.00	01700	SOCIAL SERVICE								17.00
17.01	01701	MENTAL HEALTH OH	1,375,269							17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	4,377,572						21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0		3,610,692					22.00
23.00	02300	PARAMED PRGM-RADIOLOGY	0			0				23.00
23.01	02301	PARAMED PRGM-LAB	0					286,718		23.01
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0	1,287,581	1,062,018	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	108,563	89,544	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - I/PF	697,160	439,645	362,626	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - I/RF	0	0	0	0	0	0	0	41.00
43.00	04300	NURSERY	0	0	0	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS										
50.00	05000	OPERATING ROOM	0	0	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	0	0	51.00
51.01	05101	ENDOSCOPY	0	62,036	51,168	0	0	0	0	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	18,880	15,573	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	100,471	82,870	0	0	0	0	55.00
60.00	06000	LABORATORY	0	0	0	0	0	286,718	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	41,470	34,205	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	84,625	69,800	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	0	0	0	0	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	758,927	625,976	0	0	0	0	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0	0	0	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	0	65,407	53,949	0	0	0	0	76.01
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	0	0	77.00
OUTPATIENT SERVICE COST CENTERS										
90.00	09000	CLINIC	0	0	0	0	0	0	0	90.00
90.01	04950	WOUND CLINIC	0	0	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	305,122	251,669	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS										
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	0	0	96.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	0	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS										
113.00	11300	INTEREST EXPENSE								113.00
116.00	11600	HOSPICE	0			0				116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	697,160	3,272,727	2,699,398	0		286,718		118.00
NONREIMBURSABLE COST CENTERS										
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	240,389	198,277	0	0	0	0	192.00
192.01	19201	FP PETERSBURG	0	0	0	0	0	0	0	192.01
192.02	19202	PEDIATRICS	0	0	0	0	0	0	0	192.02
192.03	19203	WASHINGTON PRIMARY CARE	0	0	0	0	0	0	0	192.03

COST ALLOCATION - GENERAL SERVICE COSTS

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Period:
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Cost Center Description	INTERNS & RESIDENTS					PARAMED PRGM-RADIOLOGY	PARAMED PRGM-LAB	
	MENTAL HEALTH OH	SERVICES-SALARY & FRINGES	SERVICES-OTHER PRGM COSTS					
	17.01	21.00	22.00	23.00	23.01			
192.04 19204 FQHC	0	0	0	0	0	0	0	192.04
194.00 07950 COMMUNITY HEALTH SERVICES	0	0	0	0	0	0	0	194.00
194.01 07960 CCBHC GRANTS	0	0	0	0	0	0	0	194.01
194.02 07952 MARKETING AND PUBLIC RELATIONS	0	0	0	0	0	0	0	194.02
194.03 07953 MH RESIDENTIAL	0	0	0	0	0	0	0	194.03
194.04 07954 UNUSED SPACE	0	0	0	0	0	0	0	194.04
194.05 07955 MOB	0	0	0	0	0	0	0	194.05
194.06 07956 FOUNDATION	0	0	0	0	0	0	0	194.06
194.07 07957 KNOX COUNTY HEALTH DEPT	0	0	0	0	0	0	0	194.07
194.08 07958 INDUSTRIAL HEALTH	0	0	0	0	0	0	0	194.08
194.09 07959 COMMUNITY MENTAL HEALTH CENTER	678,109	864,456	713,017	0	0	0	0	194.09
194.10 07951 BEI RHAUS BUILDING	0	0	0	0	0	0	0	194.10
200.00 Cross Foot Adjustments	0	0	0	0	0	0	0	200.00
201.00 Negative Cost Centers	0	0	0	0	0	0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	1,375,269	4,377,572	3,610,692	0	0	0	286,718	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0042

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

Worksheet B
Part I
Date/Time Prepared:
5/24/2023 12:05 pm

Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS					
1.00	00100				1.00
2.00	00200				2.00
4.00	00400				4.00
4.01	00401				4.01
4.02	00402				4.02
4.03	00403				4.03
4.04	00404				4.04
5.00	00500				5.00
7.00	00700				7.00
8.00	00800				8.00
9.00	00900				9.00
10.00	01000				10.00
11.00	01100				11.00
13.00	01300				13.00
14.00	01400				14.00
15.00	01500				15.00
16.00	01600				16.00
17.00	01700				17.00
17.01	01701				17.01
21.00	02100				21.00
22.00	02200				22.00
23.00	02300				23.00
23.01	02301				23.01
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	20,667,054	-2,349,599	18,317,455	30.00
31.00	03100	10,053,326	-198,107	9,855,219	31.00
40.00	04000	6,386,473	-802,271	5,584,202	40.00
41.00	04100	5,409,538	0	5,409,538	41.00
43.00	04300	780,712	0	780,712	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	7,412,017	0	7,412,017	50.00
51.00	05100	0	0	0	51.00
51.01	05101	3,142,712	-113,204	3,029,508	51.01
52.00	05200	1,914,925	0	1,914,925	52.00
53.00	05300	1,544,273	-34,453	1,509,820	53.00
54.00	05400	11,238,454	0	11,238,454	54.00
55.00	05500	6,035,379	-183,341	5,852,038	55.00
60.00	06000	11,596,267	0	11,596,267	60.00
63.00	06300	0	0	0	63.00
65.00	06500	4,066,917	-75,675	3,991,242	65.00
66.00	06600	8,874,051	0	8,874,051	66.00
69.00	06900	6,186,084	-154,425	6,031,659	69.00
70.00	07000	0	0	0	70.00
70.01	07001	1,951,208	0	1,951,208	70.01
71.00	07100	4,262,807	0	4,262,807	71.00
72.00	07200	4,897,070	0	4,897,070	72.00
73.00	07300	26,196,809	0	26,196,809	73.00
75.00	07500	5,949,549	-1,384,903	4,564,646	75.00
76.00	03950	0	0	0	76.00
76.01	03951	748,264	-119,356	628,908	76.01
77.00	07700	0	0	0	77.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	331,598	0	331,598	90.00
90.01	04950	1,544,351	0	1,544,351	90.01
91.00	09100	11,936,498	-556,791	11,379,707	91.00
92.00	09200	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
96.00	09600	231,822	0	231,822	96.00
101.00	10100	0	0	0	101.00
102.00	10200	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300				113.00
116.00	11600	1,692,437	0	1,692,437	116.00
118.00		165,050,595	-5,972,125	159,078,470	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	0	0	0	190.00
192.00	19200	33,274,641	-438,666	32,835,975	192.00
192.01	19201	787,234	0	787,234	192.01
192.02	19202	1,617,440	0	1,617,440	192.02
192.03	19203	2,515,072	0	2,515,072	192.03

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0042

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

Worksheet B
Part I
Date/Time Prepared:
5/24/2023 12:05 pm

Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		24.00	25.00	26.00	
192.04	19204 FQHC	35,825	0	35,825	192.04
194.00	07950 COMMUNITY HEALTH SERVICES	272,900	0	272,900	194.00
194.01	07960 CCBHC GRANTS	4,332,492	0	4,332,492	194.01
194.02	07952 MARKETING AND PUBLIC RELATIONS	1,023,026	0	1,023,026	194.02
194.03	07953 MH RESIDENTIAL	1,834,924	0	1,834,924	194.03
194.04	07954 UNUSED SPACE	1,084,382	0	1,084,382	194.04
194.05	07955 MOB	47,377	0	47,377	194.05
194.06	07956 FOUNDATION	25,236	0	25,236	194.06
194.07	07957 KNOX COUNTY HEALTH DEPT	250,840	0	250,840	194.07
194.08	07958 INDUSTRIAL HEALTH	0	0	0	194.08
194.09	07959 COMMUNITY MENTAL HEALTH CENTER	12,729,948	-1,577,473	11,152,475	194.09
194.10	07951 BEIRHAUS BUILDING	72,946	0	72,946	194.10
200.00	Cross Foot Adjustments	0	0	0	200.00
201.00	Negative Cost Centers	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	224,954,878	-7,988,264	216,966,614	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-0042	Period: From 01/01/2022 To 12/31/2022	Worksheet B Part II Date/Time Prepared: 5/24/2023 12:05 pm
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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	114,982	2,530	117,512	4.00
4.01 00401	COMMUNICATIONS	0	0	0	0	4.01
4.02 00402	PURCHASING & RECEIVING	0	273,738	6,024	279,762	4.02
4.03 00403	REGISTRATION	0	267,329	5,883	273,212	4.03
4.04 00404	PATIENT ACCOUNTS	0	0	0	0	4.04
5.00 00500	ADMINISTRATIVE & GENERAL	0	1,134,350	24,963	1,159,313	5.00
7.00 00700	OPERATION OF PLANT	0	5,674,111	124,862	5,798,973	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	124,536	2,741	127,277	8.00
9.00 00900	HOUSEKEEPING	0	173,253	3,813	177,066	9.00
10.00 01000	DIETARY	0	90,410	1,990	92,400	10.00
11.00 01100	CAFETERIA	0	205,652	4,526	210,178	11.00
13.00 01300	NURSING ADMINISTRATION	0	230,886	5,081	235,967	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	93,816	2,065	95,881	14.00
15.00 01500	PHARMACY	0	141,398	3,112	144,510	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	108,313	2,384	110,697	16.00
17.00 01700	SOCIAL SERVICE	0	0	0	0	17.00
17.01 01701	MENTAL HEALTH OH	0	61,606	1,356	62,962	17.01
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	239,896	5,279	245,175	21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	22.00
23.00 02300	PARAMED ED PRGM-RADIOLOGY	0	0	0	0	23.00
23.01 02301	PARAMED ED PRGM-LAB	0	0	0	0	23.01
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	1,467,825	32,302	1,500,127	30.00
31.00 03100	INTENSIVE CARE UNIT	0	495,542	10,905	506,447	31.00
40.00 04000	SUBPROVIDER - IPF	0	308,242	6,783	315,025	40.00
41.00 04100	SUBPROVIDER - IRF	0	406,598	8,948	415,546	41.00
43.00 04300	NURSERY	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	568,192	12,504	580,696	50.00
51.00 05100	RECOVERY ROOM	0	0	0	0	51.00
51.01 05101	ENDOSCOPY	0	289,393	6,369	295,762	51.01
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00 05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	512,380	11,276	523,656	54.00
55.00 05500	RADIOLOGY-THERAPEUTIC	0	425,328	9,360	434,688	55.00
60.00 06000	LABORATORY	0	172,591	3,798	176,389	60.00
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00
65.00 06500	RESPIRATORY THERAPY	0	134,303	2,956	137,259	65.00
66.00 06600	PHYSICAL THERAPY	0	670,356	14,752	685,108	66.00
69.00 06900	ELECTROCARDIOLOGY	0	429,963	9,462	439,425	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
70.01 07001	NEURODIAGNOSTICS	0	182,287	4,011	186,298	70.01
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
75.00 07500	ASC (NON-DISTINCT PART)	0	0	0	0	75.00
76.00 03950	MH ANCILLARY OUTPATIENT	0	0	0	0	76.00
76.01 03951	INPATIENT DIALYSIS	0	202,956	4,466	207,422	76.01
77.00 07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	77.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	53,305	1,173	54,478	90.00
90.01 04950	WOUND CLINIC	0	70,380	1,549	71,929	90.01
91.00 09100	EMERGENCY	0	559,749	12,318	572,067	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
96.00 09600	DURABLE MEDICAL EQUIP-RENTED	0	9,318	205	9,523	96.00
101.00 10100	HOME HEALTH AGENCY	0	0	0	0	101.00
102.00 10200	OPIOID TREATMENT PROGRAM	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE	0	0	0	0	113.00
116.00 11600	HOSPICE	0	114,958	2,530	117,488	116.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	0	16,007,942	352,276	16,360,218	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	2,697,883	59,371	2,757,254	192.00
192.01 19201	FP PETERSBURG	0	87,620	1,928	89,548	192.01
192.02 19202	PEDIATRICS	0	0	0	0	192.02

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0042

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

Worksheet B
Part II
Date/Time Prepared:
5/24/2023 12:05 pm

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	MVBLE EQUIP			
		1.00	2.00			
192.03 19203 WASHINGTON PRIMARY CARE	0	160,813	3,539	164,352	1,458	192.03
192.04 19204 FOHC	0	0	0	0	0	192.04
194.00 07950 COMMUNITY HEALTH SERVICES	0	9,814	216	10,030	165	194.00
194.01 07960 CCBHC GRANTS	0	0	0	0	2,249	194.01
194.02 07952 MARKETING AND PUBLIC RELATIONS	0	39,967	880	40,847	266	194.02
194.03 07953 MH RESIDENTIAL	0	479,130	10,544	489,674	536	194.03
194.04 07954 UNUSED SPACE	0	481,731	10,601	492,332	0	194.04
194.05 07955 MOB	0	0	0	0	0	194.05
194.06 07956 FOUNDATION	0	11,020	243	11,263	0	194.06
194.07 07957 KNOX COUNTY HEALTH DEPT	0	111,434	2,452	113,886	0	194.07
194.08 07958 INDUSTRIAL HEALTH	0	0	0	0	0	194.08
194.09 07959 COMMUNITY MENTAL HEALTH CENTER	0	830,152	18,269	848,421	6,233	194.09
194.10 07951 BEIRHAUS BUILDING	0	0	0	0	5	194.10
200.00 Cross Foot Adjustments				0		200.00
201.00 Negative Cost Centers		0	0	0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	0	20,917,506	460,319	21,377,825	117,512	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 15-0042	Period: From 01/01/2022 To 12/31/2022	Worksheet B Part II Date/Time Prepared: 5/24/2023 12:05 pm		
Cost Center Description			COMMUNICATIONS 4.01	PURCHASING & RECEIVING 4.02	REGISTRATION 4.03	PATIENT ACCOUNTS 4.04	ADMINISTRATIVE & GENERAL 5.00
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
4.01	00401	COMMUNICATIONS	328				4.01
4.02	00402	PURCHASING & RECEIVING	3	280,592			4.02
4.03	00403	REGISTRATION	5	234	275,292		4.03
4.04	00404	PATIENT ACCOUNTS	6	184	0	3,123	4.04
5.00	00500	ADMINISTRATIVE & GENERAL	27	951	0	0	5.00
7.00	00700	OPERATION OF PLANT	17	2,587	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	1,272	0	0	8.00
9.00	00900	HOUSEKEEPING	5	2,947	0	0	9.00
10.00	01000	DIETARY	1	6,021	0	0	10.00
11.00	01100	CAFETERIA	3	13,694	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	3	268	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1	1,133	0	0	14.00
15.00	01500	PHARMACY	5	443	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	7	90	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
17.01	01701	MENTAL HEALTH OH	38	147	0	0	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	8	505	0	0	22.00
23.00	02300	PARAMED ED PRGM-RADIOLOGY	0	0	0	0	23.00
23.01	02301	PARAMED ED PRGM-LAB	0	23	0	0	23.01
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	24	5,121	12,229	147	30.00
31.00	03100	INTENSIVE CARE UNIT	14	4,449	7,060	85	31.00
40.00	04000	SUBPROVIDER - I PF	0	366	3,890	47	40.00
41.00	04100	SUBPROVIDER - I RF	11	1,304	3,368	40	41.00
43.00	04300	NURSERY	0	341	596	7	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	22	11,901	20,318	244	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
51.01	05101	ENDOSCOPY	4	9,324	4,888	59	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	9	1,232	3,389	41	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	13	7,445	42,482	330	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	5	1,253	10,430	125	55.00
60.00	06000	LABORATORY	5	27,246	31,278	375	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	6	350	6,205	74	65.00
66.00	06600	PHYSICAL THERAPY	9	896	11,025	132	66.00
69.00	06900	ELECTROCARDIOLOGY	12	2,226	20,726	249	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	3	476	2,837	34	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	92,541	1	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	57,953	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	29,248	351	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	5,136	10,808	130	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0	0	76.00
76.01	03951	INPATIENT DIAGNOSIS	0	15	426	5	76.01
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	77.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	1	5	37	0	90.00
90.01	04950	WOUND CLINIC	1	1,438	2,612	31	90.01
91.00	09100	EMERGENCY	15	5,524	21,577	259	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS							
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	148	170	2	96.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	3	429	844	10	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	286	267,618	246,444	2,777	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	38	8,616	22,155	266	192.00
192.01	19201	FP PETERSBURG	0	27	235	3	192.01
192.02	19202	PEDIATRICS	3	412	1,197	14	192.02
192.03	19203	WASHINGTON PRIMARY CARE	0	344	1,317	16	192.03
192.04	19204	FQHC	0	0	30	0	192.04
194.00	07950	COMMUNITY HEALTH SERVICES	0	0	317	4	194.00
194.01	07960	CCBHC GRANTS	0	2,359	0	0	194.01

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0042

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

Worksheet B
Part II
Date/Time Prepared:
5/24/2023 12:05 pm

Cost Center Description		COMMUNICATIONS	PURCHASING & RECEIVING	REGISTRATION	PATIENT ACCOUNTS	ADMINISTRATIVE & GENERAL		
		4.01	4.02	4.03	4.04	5.00		
194.02	07952	MARKETING AND PUBLIC RELATIONS	1	6	70	1	5,026	194.02
194.03	07953	MH RESIDENTIAL	0	430	0	0	6,570	194.03
194.04	07954	UNUSED SPACE	0	0	0	0	2,811	194.04
194.05	07955	MOB	0	0	0	0	246	194.05
194.06	07956	FOUNDATION	0	0	0	0	67	194.06
194.07	07957	KNOX COUNTY HEALTH DEPT	0	0	0	0	650	194.07
194.08	07958	INDUSTRIAL HEALTH	0	0	0	0	0	194.08
194.09	07959	COMMUNITY MENTAL HEALTH CENTER	0	764	3,527	42	49,528	194.09
194.10	07951	BEIRHAUS BUILDING	0	16	0	0	379	194.10
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	328	280,592	275,292	3,123	1,168,430	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 15-0042	Period: From 01/01/2022 To 12/31/2022	Worksheet B Part II Date/Time Prepared: 5/24/2023 12:05 pm			
Cost Center Description			OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401	COMMUNICATIONS						4.01
4.02	00402	PURCHASING & RECEIVING						4.02
4.03	00403	REGISTRATION						4.03
4.04	00404	PATIENT ACCOUNTS						4.04
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	5,882,974					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	54,459	186,180				8.00
9.00	00900	HOUSEKEEPING	75,763	8,961	284,787			9.00
10.00	01000	DIETARY	39,536	655	7,787	154,153		10.00
11.00	01100	CAFETERIA	89,931	1,490	1,945	0	328,994	11.00
13.00	01300	NURSING ADMINISTRATION	100,966	0	0	0	7,040	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	41,025	2,973	3,447	0	2,426	14.00
15.00	01500	PHARMACY	61,833	0	2,743	0	10,919	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	47,365	0	2,017	0	19,243	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
17.01	01701	MENTAL HEALTH OH	26,940	0	8,166	0	1,679	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	104,906	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	2,581	0	4,792	22.00
23.00	02300	PARAMED PRGM-RADIOLOGY	0	0	0	0	0	23.00
23.01	02301	PARAMED PRGM-LAB	0	0	0	0	881	23.01
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	641,878	65,506	68,415	69,871	23,596	30.00
31.00	03100	INTENSIVE CARE UNIT	216,700	12,002	17,483	28,685	12,595	31.00
40.00	04000	SUBPROVIDER - I PF	134,794	3,745	0	22,987	9,748	40.00
41.00	04100	SUBPROVIDER - IRF	177,805	9,490	11,951	32,610	9,806	41.00
43.00	04300	NURSERY	0	496	654	0	1,372	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	248,469	8,653	16,914	0	10,763	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
51.01	05101	ENDOSCOPY	126,551	5,509	4,543	0	3,881	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	2,175	830	0	4,687	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	2,644	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	224,063	11,722	9,506	0	17,775	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	185,995	1,848	5,053	0	10,030	55.00
60.00	06000	LABORATORY	75,474	0	4,345	0	14,457	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	58,730	95	3,303	0	9,893	65.00
66.00	06600	PHYSICAL THERAPY	293,146	2,035	8,044	0	22,283	66.00
69.00	06900	ELECTROCARDIOLOGY	188,022	5,571	12,876	0	12,504	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	79,714	2,168	2,260	0	2,987	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	5,487	13,002	0	5,818	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	88,752	0	0	0	0	76.01
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	23,310	22	4,922	0	500	90.00
90.01	04950	WOUND CLINIC	30,777	2,775	1,444	0	1,477	90.01
91.00	09100	EMERGENCY	244,777	25,028	19,341	0	18,698	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	4,075	0	0	0	573	96.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	50,271	0	3,875	0	2,595	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,736,027	178,406	237,447	154,153	245,662	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,179,783	7,774	45,554	0	49,077	192.00
192.01	19201	FP PETERSBURG	38,316	0	0	0	1,398	192.01
192.02	19202	PEDIATRICS	0	0	0	0	3,588	192.02
192.03	19203	WASHINGTON PRIMARY CARE	70,323	0	0	0	4,906	192.03
192.04	19204	FQHC	0	0	0	0	5,102	192.04
194.00	07950	COMMUNITY HEALTH SERVICES	4,292	0	1,493	0	736	194.00
194.01	07960	CCBHC GRANTS	0	0	131	0	13,208	194.01

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-0042			Period: From 01/01/2022 To 12/31/2022		Worksheet B Part II Date/Time Prepared: 5/24/2023 12:05 pm	
Cost Center Description		OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA		
		7.00	8.00	9.00	10.00	11.00		
194.02	07952	MARKETING AND PUBLIC RELATIONS	17,477	0	162	0	1,204	194.02
194.03	07953	MH RESIDENTIAL	209,523	0	0	0	4,113	194.03
194.04	07954	UNUSED SPACE	210,660	0	0	0	0	194.04
194.05	07955	MOB	0	0	0	0	0	194.05
194.06	07956	FOUNDATION	4,819	0	0	0	0	194.06
194.07	07957	KNOX COUNTY HEALTH DEPT	48,730	0	0	0	0	194.07
194.08	07958	INDUSTRIAL HEALTH	0	0	0	0	0	194.08
194.09	07959	COMMUNITY MENTAL HEALTH CENTER	363,024	0	0	0	0	194.09
194.10	07951	BEIRHAUS BUILDING	0	0	0	0	0	194.10
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	5,882,974	186,180	284,787	154,153	328,994	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 15-0042	Period: From 01/01/2022 To 12/31/2022	Worksheet B Part II Date/Time Prepared: 5/24/2023 12:05 pm		
Cost Center Description			NURSING ADMINISTRATIVE	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE
			13.00	14.00	15.00	16.00	17.00
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
4.01	00401	COMMUNICATIONS					4.01
4.02	00402	PURCHASING & RECEIVING					4.02
4.03	00403	REGISTRATION					4.03
4.04	00404	PATIENT ACCOUNTS					4.04
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION	363,917				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	151,064			14.00
15.00	01500	PHARMACY	0	266	247,321		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	54	0	213,033	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
17.01	01701	MENTAL HEALTH OH	0	88	0	0	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	14,535	303	235	0	22.00
23.00	02300	PARAMED ED PRGM-RADIOLOGY	0	0	0	0	23.00
23.01	02301	PARAMED ED PRGM-LAB	0	14	0	0	23.01
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	64,245	3,079	1	27,775	30.00
31.00	03100	INTENSIVE CARE UNIT	38,203	2,674	0	24,270	31.00
40.00	04000	SUBPROVIDER - IPF	29,323	220	0	26,697	40.00
41.00	04100	SUBPROVIDER - IRF	29,741	784	0	18,876	41.00
43.00	04300	NURSERY	4,161	205	1	2,157	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	23,698	7,154	217	9,169	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
51.01	05101	ENDOSCOPY	11,770	5,605	530	0	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	17,872	741	4	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,456	4,476	1,289	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	19,386	753	48	0	55.00
60.00	06000	LABORATORY	0	16,379	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	211	14	0	65.00
66.00	06600	PHYSICAL THERAPY	16,626	539	1,328	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	1,338	666	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	1,496	286	1	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	55,626	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	34,838	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	227,834	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	17,646	3,088	187	58,516	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	0	9	9	0	76.01
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	77.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	3	3	0	90.00
90.01	04950	WOUND CLINIC	997	865	189	2,697	90.01
91.00	09100	EMERGENCY	56,713	3,320	139	42,876	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS							
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	89	0	0	96.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	7,872	258	72	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	359,740	143,265	232,767	213,033	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	4,177	5,180	13,315	0	192.00
192.01	19201	FP PETERSBURG	0	16	256	0	192.01
192.02	19202	PEDIATRICS	0	248	465	0	192.02
192.03	19203	WASHNGTON PRIMARY CARE	0	207	505	0	192.03
192.04	19204	FOHC	0	0	0	0	192.04
194.00	07950	COMMUNITY HEALTH SERVICES	0	0	13	0	194.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0042

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

Worksheet B
Part II
Date/Time Prepared:
5/24/2023 12:05 pm

Cost Center Description		NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		13.00	14.00	15.00	16.00	17.00	
194.01	07960 CCBHC GRANTS	0	1,418	0	0	0	194.01
194.02	07952 MARKETING AND PUBLIC RELATIONS	0	4	0	0	0	194.02
194.03	07953 MH RESIDENTIAL	0	258	0	0	0	194.03
194.04	07954 UNUSED SPACE	0	0	0	0	0	194.04
194.05	07955 MOB	0	0	0	0	0	194.05
194.06	07956 FOUNDATION	0	0	0	0	0	194.06
194.07	07957 KNOX COUNTY HEALTH DEPT	0	0	0	0	0	194.07
194.08	07958 INDUSTRIAL HEALTH	0	0	0	0	0	194.08
194.09	07959 COMMUNITY MENTAL HEALTH CENTER	0	459	0	0	0	194.09
194.10	07951 BEIRHAUS BUILDING	0	9	0	0	0	194.10
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	363,917	151,064	247,321	213,033	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0042

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

Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description	INTERNS & RESIDENTS					
	MENTAL HEALTH OH	SERVICES-SALARY & FRINGES	SERVICES-OTHER PRGM COSTS	PARAMED PRGM-RADIOLOGY	PARAMED PRGM-LAB	
		17.01	21.00	22.00	23.00	
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
4.01 00401	COMMUNICATIONS					4.01
4.02 00402	PURCHASING & RECEIVING					4.02
4.03 00403	REGISTRATION					4.03
4.04 00404	PATIENT ACCOUNTS					4.04
5.00 00500	ADMINISTRATIVE & GENERAL					5.00
7.00 00700	OPERATION OF PLANT					7.00
8.00 00800	LAUNDRY & LINEN SERVICE					8.00
9.00 00900	HOUSEKEEPING					9.00
10.00 01000	DIETARY					10.00
11.00 01100	CAFETERIA					11.00
13.00 01300	NURSING ADMINISTRATION					13.00
14.00 01400	CENTRAL SERVICES & SUPPLY					14.00
15.00 01500	PHARMACY					15.00
16.00 01600	MEDICAL RECORDS & LIBRARY					16.00
17.00 01700	SOCIAL SERVICE					17.00
17.01 01701	MENTAL HEALTH OH	106,768				17.01
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	371,413			21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0		42,758		22.00
23.00 02300	PARAMED PRGM-RADIOLOGY	0			0	23.00
23.01 02301	PARAMED PRGM-LAB	0				2,608 23.01
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0				30.00
31.00 03100	INTENSIVE CARE UNIT	0				31.00
40.00 04000	SUBPROVIDER - IPF	54,121				40.00
41.00 04100	SUBPROVIDER - IRF	0				41.00
43.00 04300	NURSERY	0				43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0				50.00
51.00 05100	RECOVERY ROOM	0				51.00
51.01 05101	ENDOSCOPY	0				51.01
52.00 05200	DELIVERY ROOM & LABOR ROOM	0				52.00
53.00 05300	ANESTHESIOLOGY	0				53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0				54.00
55.00 05500	RADIOLOGY-THERAPEUTIC	0				55.00
60.00 06000	LABORATORY	0				60.00
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	0				63.00
65.00 06500	RESPIRATORY THERAPY	0				65.00
66.00 06600	PHYSICAL THERAPY	0				66.00
69.00 06900	ELECTROCARDIOLOGY	0				69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0				70.00
70.01 07001	NEURODIAGNOSTICS	0				70.01
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0				71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0				72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0				73.00
75.00 07500	ASC (NON-DISTINCT PART)	0				75.00
76.00 03950	MH ANCILLARY OUTPATIENT	0				76.00
76.01 03951	INPATIENT DIALYSIS	0				76.01
77.00 07700	ALLOGENEIC HSCT ACQUISITION	0				77.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0				90.00
90.01 04950	WOUND CLINIC	0				90.01
91.00 09100	EMERGENCY	0				91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0				92.00
OTHER REIMBURSABLE COST CENTERS						
96.00 09600	DURABLE MEDICAL EQUIP-RENTED	0				96.00
101.00 10100	HOME HEALTH AGENCY	0				101.00
102.00 10200	OPIOID TREATMENT PROGRAM	0				102.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
116.00 11600	HOSPICE	0				116.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	54,121	0	0	0	0 118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0				190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0				192.00
192.01 19201	FP PETERSBURG	0				192.01
192.02 19202	PEDIATRICS	0				192.02
192.03 19203	WASHINGTON PRIMARY CARE	0				192.03

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0042

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

Worksheet B
Part II
Date/Time Prepared:
5/24/2023 12:05 pm

Cost Center Description	INTERNS & RESIDENTS					
	MENTAL HEALTH OH	SERVICES-SALARY & FRINGES	SERVICES-OTHER PRGM COSTS	PARAMED ED PRGM-RADIOLOGY	PARAMED ED PRGM-LAB	
		17.01	21.00	22.00	23.00	
192.04 19204 FQHC	0					192.04
194.00 07950 COMMUNITY HEALTH SERVICES	0					194.00
194.01 07960 CCBHC GRANTS	0					194.01
194.02 07952 MARKETING AND PUBLIC RELATIONS	0					194.02
194.03 07953 MH RESIDENTIAL	0					194.03
194.04 07954 UNUSED SPACE	0					194.04
194.05 07955 MOB	0					194.05
194.06 07956 FOUNDATION	0					194.06
194.07 07957 KNOX COUNTY HEALTH DEPT	0					194.07
194.08 07958 INDUSTRIAL HEALTH	0					194.08
194.09 07959 COMMUNITY MENTAL HEALTH CENTER	52,647					194.09
194.10 07951 BEI RHAUS BUILDING	0					194.10
200.00 Cross Foot Adjustments		371,413	42,758	0	2,608	200.00
201.00 Negative Cost Centers	0	0	0	0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	106,768	371,413	42,758	0	2,608	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0042

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

Worksheet B
Part II
Date/Time Prepared:
5/24/2023 12:05 pm

Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS					
1.00	00100				1.00
2.00	00200				2.00
4.00	00400				4.00
4.01	00401				4.01
4.02	00402				4.02
4.03	00403				4.03
4.04	00404				4.04
5.00	00500				5.00
7.00	00700				7.00
8.00	00800				8.00
9.00	00900				9.00
10.00	01000				10.00
11.00	01100				11.00
13.00	01300				13.00
14.00	01400				14.00
15.00	01500				15.00
16.00	01600				16.00
17.00	01700				17.00
17.01	01701				17.01
21.00	02100				21.00
22.00	02200				22.00
23.00	02300				23.00
23.01	02301				23.01
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	2,556,000	0	2,556,000	30.00
31.00	03100	913,274	0	913,274	31.00
40.00	04000	619,468	0	619,468	40.00
41.00	04100	731,837	0	731,837	41.00
43.00	04300	13,884	0	13,884	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	972,586	0	972,586	50.00
51.00	05100	0	0	0	51.00
51.01	05101	481,933	0	481,933	51.01
52.00	05200	40,829	0	40,829	52.00
53.00	05300	13,524	0	13,524	53.00
54.00	05400	906,602	0	906,602	54.00
55.00	05500	699,603	0	699,603	55.00
60.00	06000	404,798	0	404,798	60.00
63.00	06300	0	0	0	63.00
65.00	06500	238,240	0	238,240	65.00
66.00	06600	1,087,688	0	1,087,688	66.00
69.00	06900	715,567	0	715,567	69.00
70.00	07000	0	0	0	70.00
70.01	07001	288,066	0	288,066	70.01
71.00	07100	168,558	0	168,558	71.00
72.00	07200	117,130	0	117,130	72.00
73.00	07300	370,706	0	370,706	73.00
75.00	07500	133,950	0	133,950	75.00
76.00	03950	0	0	0	76.00
76.01	03951	298,715	0	298,715	76.01
77.00	07700	0	0	0	77.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	84,459	0	84,459	90.00
90.01	04950	124,556	0	124,556	90.01
91.00	09100	1,059,075	0	1,059,075	91.00
92.00	09200	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
96.00	09600	15,812	0	15,812	96.00
101.00	10100	0	0	0	101.00
102.00	10200	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300				113.00
116.00	11600	191,622	0	191,622	116.00
118.00		13,248,482	0	13,248,482	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	0	0	0	190.00
192.00	19200	4,256,935	0	4,256,935	192.00
192.01	19201	133,575	0	133,575	192.01
192.02	19202	15,285	0	15,285	192.02
192.03	19203	255,318	0	255,318	192.03

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0042

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

Worksheet B
Part II
Date/Time Prepared:
5/24/2023 12:05 pm

Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		24.00	25.00	26.00	
192.04	19204 FQHC	5,137	0	5,137	192.04
194.00	07950 COMMUNITY HEALTH SERVICES	18,283	0	18,283	194.00
194.01	07960 CCBHC GRANTS	41,345	0	41,345	194.01
194.02	07952 MARKETING AND PUBLIC RELATIONS	65,064	0	65,064	194.02
194.03	07953 MH RESIDENTIAL	711,104	0	711,104	194.03
194.04	07954 UNUSED SPACE	705,803	0	705,803	194.04
194.05	07955 MOB	246	0	246	194.05
194.06	07956 FOUNDATION	16,149	0	16,149	194.06
194.07	07957 KNOX COUNTY HEALTH DEPT	163,266	0	163,266	194.07
194.08	07958 INDUSTRIAL HEALTH	0	0	0	194.08
194.09	07959 COMMUNITY MENTAL HEALTH CENTER	1,324,645	0	1,324,645	194.09
194.10	07951 BEI RHAUS BUILDING	409	0	409	194.10
200.00	Cross Foot Adjustments	416,779	0	416,779	200.00
201.00	Negative Cost Centers	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	21,377,825	0	21,377,825	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0042

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

Worksheet B-1

Date/Time Prepared: 5/24/2023 12:05 pm

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	COMMUNICATIONS (NUMBER OF PHONES)	PURCHASING & RECEIVING (SUPPLIES COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
	1.00	2.00				
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	884,497				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		884,497			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	4,862	4,862	106,294,879		4.00
4.01 00401	COMMUNICATIONS	0	0	296,862	2,257	4.01
4.02 00402	PURCHASING & RECEIVING	11,575	11,575	747,817	20	19,279,843 4.02
4.03 00403	REGISTRATION	11,304	11,304	1,664,815	35	16,055 4.03
4.04 00404	PATIENT ACCOUNTS	0	0	2,652,056	44	12,666 4.04
5.00 00500	ADMINISTRATIVE & GENERAL	47,966	47,966	7,359,071	184	65,337 5.00
7.00 00700	OPERATION OF PLANT	239,930	239,930	2,349,223	120	177,775 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	5,266	5,266	222,784	0	87,368 8.00
9.00 00900	HOUSEKEEPING	7,326	7,326	2,112,199	37	202,520 9.00
10.00 01000	DIETARY	3,823	3,823	561,294	8	413,702 10.00
11.00 01100	CAFETERIA	8,696	8,696	1,276,604	19	940,920 11.00
13.00 01300	NURSING ADMINISTRATION	9,763	9,763	1,864,857	19	18,433 13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	3,967	3,967	311,231	7	77,856 14.00
15.00 01500	PHARMACY	5,979	5,979	2,950,603	31	30,435 15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	4,580	4,580	3,662,513	47	6,208 16.00
17.00 01700	SOCIAL SERVICE	0	0	0	0	0 17.00
17.01 01701	MENTAL HEALTH OH	2,605	2,605	515,346	259	10,084 17.01
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	10,144	10,144	0	0	0 21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	1,977,325	52	34,679 22.00
23.00 02300	PARAMED ED PRGM-RADIOLOGY	0	0	0	0	0 23.00
23.01 02301	PARAMED ED PRGM-LAB	0	0	210,226	0	1,555 23.01
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	62,067	62,067	4,832,476	165	351,881 30.00
31.00 03100	INTENSIVE CARE UNIT	20,954	20,954	2,999,237	96	305,658 31.00
40.00 04000	SUBPROVIDER - I/PF	13,034	13,034	1,811,804	0	25,138 40.00
41.00 04100	SUBPROVIDER - I/RF	17,193	17,193	1,977,908	73	89,628 41.00
43.00 04300	NURSERY	0	0	434,565	0	23,443 43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	24,026	24,026	3,348,366	148	817,741 50.00
51.00 05100	RECOVERY ROOM	0	0	0	0	0 51.00
51.01 05101	ENDOSCOPY	12,237	12,237	782,117	26	640,619 51.01
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	1,025,763	63	84,643 52.00
53.00 05300	ANESTHESIOLOGY	0	0	2,831,501	0	0 53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	21,666	21,666	4,582,047	90	511,571 54.00
55.00 05500	RADIOLOGY-THERAPEUTIC	17,985	17,985	3,494,466	36	86,110 55.00
60.00 06000	LABORATORY	7,298	7,298	2,202,773	34	1,872,053 60.00
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0 63.00
65.00 06500	RESPIRATORY THERAPY	5,679	5,679	2,474,867	39	24,063 65.00
66.00 06600	PHYSICAL THERAPY	28,346	28,346	6,098,289	60	61,585 66.00
69.00 06900	ELECTROCARDIOLOGY	18,181	18,181	4,212,839	80	152,937 69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0 70.00
70.01 07001	NEURODIAGNOSTICS	7,708	7,708	746,643	20	32,691 70.01
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	6,358,707 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	3,981,939 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0 73.00
75.00 07500	ASC (NON-DISTINCT PART)	0	0	1,042,332	0	352,925 75.00
76.00 03950	MH ANCILLARY OUTPATIENT	0	0	0	0	0 76.00
76.01 03951	INPATIENT DIALYSIS	8,582	8,582	0	3	1,036 76.01
77.00 07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0 77.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	2,254	2,254	101,920	10	372 90.00
90.01 04950	WOUND CLINIC	2,976	2,976	368,555	10	98,819 90.01
91.00 09100	EMERGENCY	23,669	23,669	4,246,569	101	379,525 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					
OTHER REIMBURSABLE COST CENTERS						
96.00 09600	DURABLE MEDICAL EQUIP-RENTED	394	394	95,876	0	10,159 96.00
101.00 10100	HOME HEALTH AGENCY	0	0	0	0	0 101.00
102.00 10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0 102.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					
116.00 11600	HOSPICE	4,861	4,861	513,668	23	29,505 116.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	676,896	676,896	80,959,407	1,959	18,388,341 118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0 190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	114,080	114,080	14,188,000	268	592,019 192.00
192.01 19201	FP PETERSBURG	3,705	3,705	249,559	0	1,847 192.01

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0042

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

Worksheet B-1

Date/Time Prepared:
5/24/2023 12:05 pm

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	COMMUNICATIONS (NUMBER OF PHONES)	PURCHASING & RECEIVING (SUPPLIES COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
	1.00	2.00				
192.02 19202 PEDIATRICS	0	0	1,029,933	20	28,340	192.02
192.03 19203 WASHINGTON PRIMARY CARE	6,800	6,800	1,318,539	0	23,651	192.03
192.04 19204 FOHC	0	0	1	0	0	192.04
194.00 07950 COMMUNITY HEALTH SERVICES	415	415	149,389	2	0	194.00
194.01 07960 CCBHC GRANTS	0	0	2,033,632	0	162,103	194.01
194.02 07952 MARKETING AND PUBLIC RELATIONS	1,690	1,690	240,743	5	437	194.02
194.03 07953 MH RESIDENTIAL	20,260	20,260	484,868	0	29,512	194.03
194.04 07954 UNUSED SPACE	20,370	20,370	0	0	0	194.04
194.05 07955 MOB	0	0	0	0	0	194.05
194.06 07956 FOUNDATION	466	466	0	3	0	194.06
194.07 07957 KNOX COUNTY HEALTH DEPT	4,712	4,712	0	0	0	194.07
194.08 07958 INDUSTRIAL HEALTH	0	0	0	0	0	194.08
194.09 07959 COMMUNITY MENTAL HEALTH CENTER	35,103	35,103	5,635,979	0	52,512	194.09
194.10 07951 BEIRHAUS BUILDING	0	0	4,829	0	1,081	194.10
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers						201.00
202.00 Cost to be allocated (per Wkst. B, Part I)	20,917,506	460,319	28,172,208	293,529	1,362,741	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	23.649041	0.520430	0.265038	130.052725	0.070682	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)			117,512	328	280,592	204.00
205.00 Unit cost multiplier (Wkst. B, Part II)			0.001106	0.145326	0.014554	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: 15-0042

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

Worksheet B-1

Date/Time Prepared:
5/24/2023 12:05 pm

Cost Center Description		REGISTRATION (GROSS CHARGES)	PATIENT ACCOUNTS (GROSS CHARGES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
		4.03	4.04	5A	5.00	7.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
4.01	00401	COMMUNICATIONS					4.01
4.02	00402	PURCHASING & RECEIVING					4.02
4.03	00403	REGISTRATION	660,027,621				4.03
4.04	00404	PATIENT ACCOUNTS	0	660,027,621			4.04
5.00	00500	ADMINISTRATIVE & GENERAL	0	0	-20,288,599	204,666,279	5.00
7.00	00700	OPERATION OF PLANT	0	0	0	13,802,603	568,860
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	512,523	5,266
9.00	00900	HOUSEKEEPING	0	0	0	3,102,002	7,326
10.00	01000	DIETARY	0	0	0	1,249,218	3,823
11.00	01100	CAFETERIA	0	0	0	1,811,410	8,696
13.00	01300	NURSING ADMINISTRATION	0	0	0	3,084,527	9,763
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	671,653	3,967
15.00	01500	PHARMACY	0	0	0	4,088,038	5,979
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	5,168,925	4,580
17.00	01700	SOCIAL SERVICE	0	0	0	0	0
17.01	01701	MENTAL HEALTH OH	0	0	0	1,082,149	2,605
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	3,736,631	10,144
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	3,084,975	0
23.00	02300	PARAMED ED PRGM RADIOLOGY	0	0	0	0	0
23.01	02301	PARAMED ED PRGM-LAB	0	0	0	255,294	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	29,325,343	29,325,343	0	12,023,285	62,067
31.00	03100	INTENSIVE CARE UNIT	16,931,150	16,931,150	0	6,882,067	20,954
40.00	04000	SUBPROVIDER - IPF	9,327,474	9,327,474	0	2,890,397	13,034
41.00	04100	SUBPROVIDER - IRF	8,076,659	8,076,659	0	3,208,368	17,193
43.00	04300	NURSERY	1,429,086	1,429,086	0	597,891	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	48,724,660	48,724,660	0	5,371,280	24,026
51.00	05100	RECOVERY ROOM	0	0	0	0	0
51.01	05101	ENDOSCOPY	11,720,766	11,720,766	0	2,214,371	12,237
52.00	05200	DELIVERY ROOM & LABOR ROOM	8,126,068	8,126,068	0	1,526,456	0
53.00	05300	ANESTHESIOLOGY	0	0	0	1,357,173	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	101,735,865	101,735,865	0	9,339,852	21,666
55.00	05500	RADIOLOGY-THERAPEUTIC	25,013,062	25,013,062	0	4,576,000	17,985
60.00	06000	LABORATORY	75,006,225	75,006,225	0	9,881,522	7,298
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	14,879,570	14,879,570	0	3,391,703	5,679
66.00	06600	PHYSICAL THERAPY	26,438,823	26,438,823	0	6,966,571	28,346
69.00	06900	ELECTROCARDIOLOGY	49,703,275	49,703,275	0	4,780,725	18,181
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0
70.01	07001	NEURODIAGNOSTICS	6,802,876	6,802,876	0	1,520,439	7,708
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,911	1,911	0	3,571,470	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	4,263,237	0
73.00	07300	DRUGS CHARGED TO PATIENTS	70,139,207	70,139,207	0	19,841,158	0
75.00	07500	ASC (NON-DISTINCT PART)	25,919,018	25,919,018	0	2,273,389	0
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0	0	0
76.01	03951	INPATIENT DIALYSIS	1,020,772	1,020,772	0	363,743	8,582
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	89,313	89,313	0	186,515	2,254
90.01	04950	WOUND CLINIC	6,263,026	6,263,026	0	1,211,365	2,976
91.00	09100	EMERGENCY	51,742,256	51,742,256	0	7,714,841	23,669
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
OTHER REIMBURSABLE COST CENTERS							
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	407,736	407,736	0	197,294	394
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	2,023,096	2,023,096	0	1,285,156	4,861
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	590,847,237	590,847,237	-20,288,599	159,086,216	361,259
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	53,130,448	53,130,448	0	25,943,840	114,080
192.01	19201	FP PETERSBURG	562,532	562,532	0	613,053	3,705
192.02	19202	PEDIATRICS	2,871,198	2,871,198	0	1,439,689	0
192.03	19203	WASHINGTON PRIMARY CARE	3,158,822	3,158,822	0	2,082,678	6,800
192.04	19204	FQHC	71,663	71,663	0	801	0

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0042

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

Worksheet B-1

Date/Time Prepared:
5/24/2023 12:05 pm

Cost Center Description		REGISTRATION (GROSS CHARGES)	PATIENT ACCOUNTS (GROSS CHARGES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
		4.03	4.04	5A	5.00	7.00	
194.00	07950 COMMUNITY HEALTH SERVICES	759,600	759,600	0	216,045	415	194.00
194.01	07960 CCBHC GRANTS	0	0	0	3,850,094	0	194.01
194.02	07952 MARKETING AND PUBLIC RELATIONS	167,638	167,638	0	880,344	1,690	194.02
194.03	07953 MH RESIDENTIAL	0	0	0	1,150,800	20,260	194.03
194.04	07954 UNUSED SPACE	0	0	0	492,332	20,370	194.04
194.05	07955 MOB	0	0	0	43,104	0	194.05
194.06	07956 FOUNDATION	0	0	0	11,653	466	194.06
194.07	07957 KNOX COUNTY HEALTH DEPT	0	0	0	113,886	4,712	194.07
194.08	07958 INDUSTRIAL HEALTH	0	0	0	0	0	194.08
194.09	07959 COMMUNITY MENTAL HEALTH CENTER	8,458,483	8,458,483	0	8,675,429	35,103	194.09
194.10	07951 BEI RHAUS BUILDING	0	0	0	66,315	0	194.10
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	2,418,232	4,944,609		20,288,599	15,170,855	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0.003664	0.007492		0.099130	26.668873	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	275,292	3,123		1,168,430	5,882,974	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.000417	0.000005		0.005709	10.341690	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: 15-0042		Period: From 01/01/2022 To 12/31/2022		Worksheet B-1	
Date/Time Prepared: 5/24/2023 12:05 pm								
Cost Center Description			LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (PATIENT DAYS)	CAFETERIA (MAN HOURS)	NURSING ADMINISTRATIVE (DIRECT NURSING)	
			8.00	9.00	10.00	11.00	13.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401	COMMUNICATIONS						4.01
4.02	00402	PURCHASING & RECEIVING						4.02
4.03	00403	REGISTRATION						4.03
4.04	00404	PATIENT ACCOUNTS						4.04
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE	768,512					8.00
9.00	00900	HOUSEKEEPING	36,991	63,123				9.00
10.00	01000	DIETARY	2,705	1,726	28,514			10.00
11.00	01100	CAFETERIA	6,151	431	0	2,065,908		11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	44,205	753,426	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	12,274	764	0	15,235	0	14.00
15.00	01500	PHARMACY	0	608	0	68,566	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	447	0	120,839	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
17.01	01701	MENTAL HEALTH OH	0	1,810	0	10,545	0	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	572	0	30,092	30,092	22.00
23.00	02300	PARAMED PRGM-RADIOLOGY	0	0	0	0	0	23.00
23.01	02301	PARAMED PRGM-LAB	0	0	0	5,533	0	23.01
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	270,389	15,164	12,924	148,172	133,007	30.00
31.00	03100	INTENSIVE CARE UNIT	49,540	3,875	5,306	79,092	79,092	31.00
40.00	04000	SUBPROVIDER - I/PF	15,458	0	4,252	61,213	60,709	40.00
41.00	04100	SUBPROVIDER - I/RF	39,171	2,649	6,032	61,574	61,574	41.00
43.00	04300	NURSERY	2,048	145	0	8,614	8,614	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	35,718	3,749	0	67,586	49,063	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
51.01	05101	ENDOSCOPY	22,742	1,007	0	24,368	24,368	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	8,979	184	0	29,431	37,001	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	16,603	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	48,386	2,107	0	111,620	11,296	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	7,627	1,120	0	62,984	40,135	55.00
60.00	06000	LABORATORY	0	963	0	90,785	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	393	732	0	62,122	0	65.00
66.00	06600	PHYSICAL THERAPY	8,399	1,783	0	139,924	34,422	66.00
69.00	06900	ELECTROCARDIOLOGY	22,995	2,854	0	78,518	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	8,949	501	0	18,759	3,097	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	22,651	2,882	0	36,532	36,532	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	0	0	0	0	0	76.01
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	92	1,091	0	3,142	0	90.00
90.01	04950	WOUND CLINIC	11,453	320	0	9,274	2,065	90.01
91.00	09100	EMERGENCY	103,311	4,287	0	117,415	117,415	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	3,597	0	96.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	859	0	16,297	16,297	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	736,422	52,630	28,514	1,542,637	744,779	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	32,090	10,097	0	308,172	8,647	192.00
192.01	19201	FP PETERSBURG	0	0	0	8,780	0	192.01
192.02	19202	PEDIATRICS	0	0	0	22,530	0	192.02
192.03	19203	WASHINGTON PRIMARY CARE	0	0	0	30,804	0	192.03

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0042

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

Worksheet B-1

Date/Time Prepared:
5/24/2023 12:05 pm

Cost Center Description		LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (PATIENT DAYS)	CAFETERIA (MAN HOURS)	NURSING ADMINISTRATIVE (DIRECT NURSING)	
		8.00	9.00	10.00	11.00	13.00	
192.04	19204 FQHC	0	0	0	32,037	0	192.04
194.00	07950 COMMUNITY HEALTH SERVICES	0	331	0	4,622	0	194.00
194.01	07960 CCBHC GRANTS	0	29	0	82,941	0	194.01
194.02	07952 MARKETING AND PUBLIC RELATIONS	0	36	0	7,559	0	194.02
194.03	07953 MH RESIDENTIAL	0	0	0	25,826	0	194.03
194.04	07954 UNUSED SPACE	0	0	0	0	0	194.04
194.05	07955 MOB	0	0	0	0	0	194.05
194.06	07956 FOUNDATION	0	0	0	0	0	194.06
194.07	07957 KNOX COUNTY HEALTH DEPT	0	0	0	0	0	194.07
194.08	07958 INDUSTRIAL HEALTH	0	0	0	0	0	194.08
194.09	07959 COMMUNITY MENTAL HEALTH CENTER	0	0	0	0	0	194.09
194.10	07951 BEIRHAUS BUILDING	0	0	0	0	0	194.10
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	703,767	3,638,754	1,576,981	2,253,366	3,698,880	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0.915753	57.645454	55.305499	1.090739	4.909414	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	186,180	284,787	154,153	328,994	363,917	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.242260	4.511620	5.406222	0.159249	0.483016	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: 15-0042

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

Worksheet B-1
Date/Time Prepared:
5/24/2023 12:05 pm

Cost Center Description		CENTRAL SERVICES & SUPPLY (SUPPLIES COST)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (NET CHARGES)	MENTAL HEALTH OH (NET CHARGES)	
		14.00	15.00	16.00	17.00	17.01	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
4.01	00401						4.01
4.02	00402						4.02
4.03	00403						4.03
4.04	00404						4.04
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100						11.00
13.00	01300						13.00
14.00	01400	17,267,211					14.00
15.00	01500	30,435	21,108,445				15.00
16.00	01600	6,208	0	790			16.00
17.00	01700	0	0	0	0		17.00
17.01	01701	10,084	0	0	0	17,257,471	17.01
21.00	02100	0	0	0	0	0	21.00
22.00	02200	34,679	20,083	0	0	0	22.00
23.00	02300	0	0	0	0	0	23.00
23.01	02301	1,555	0	0	0	0	23.01
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	351,881	107	103	0	0	30.00
31.00	03100	305,658	0	90	0	0	31.00
40.00	04000	25,138	0	99	0	8,748,239	40.00
41.00	04100	89,628	0	70	0	0	41.00
43.00	04300	23,443	88	8	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	817,741	18,533	34	0	0	50.00
51.00	05100	0	0	0	0	0	51.00
51.01	05101	640,619	45,243	0	0	0	51.01
52.00	05200	84,643	336	0	0	0	52.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	511,571	109,987	0	0	0	54.00
55.00	05500	86,110	4,103	0	0	0	55.00
60.00	06000	1,872,053	28	0	0	0	60.00
63.00	06300	0	0	0	0	0	63.00
65.00	06500	24,063	1,217	0	0	0	65.00
66.00	06600	61,585	113,314	0	0	0	66.00
69.00	06900	152,937	56,805	0	0	0	69.00
70.00	07000	0	0	0	0	0	70.00
70.01	07001	32,691	43	0	0	0	70.01
71.00	07100	6,358,707	0	0	0	0	71.00
72.00	07200	3,981,939	0	0	0	0	72.00
73.00	07300	0	19,445,221	0	0	0	73.00
75.00	07500	352,925	15,993	217	0	0	75.00
76.00	03950	0	0	0	0	0	76.00
76.01	03951	1,036	799	0	0	0	76.01
77.00	07700	0	0	0	0	0	77.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	372	266	0	0	0	90.00
90.01	04950	98,819	16,150	10	0	0	90.01
91.00	09100	379,525	11,857	159	0	0	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
96.00	09600	10,159	0	0	0	0	96.00
101.00	10100	0	0	0	0	0	101.00
102.00	10200	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
116.00	11600	29,505	6,108	0	0	0	116.00
118.00		16,375,709	19,866,281	790	0	8,748,239	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	592,019	1,136,408	0	0	0	192.00
192.01	19201	1,847	21,827	0	0	0	192.01
192.02	19202	28,340	39,689	0	0	0	192.02
192.03	19203	23,651	43,136	0	0	0	192.03

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0042

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

Worksheet B-1

Date/Time Prepared:
5/24/2023 12:05 pm

Cost Center Description			CENTRAL SERVICES & SUPPLIES (SUPPLIES COST)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (NET CHARGES)	MENTAL HEALTH OH (NET CHARGES)	
			14.00	15.00	16.00	17.00	17.01	
192.04	19204	FQHC	0	5	0	0	0	192.04
194.00	07950	COMMUNITY HEALTH SERVICES	0	1,099	0	0	0	194.00
194.01	07960	CCBHC GRANTS	162,103	0	0	0	0	194.01
194.02	07952	MARKETING AND PUBLIC RELATIONS	437	0	0	0	0	194.02
194.03	07953	MH RESIDENTIAL	29,512	0	0	0	0	194.03
194.04	07954	UNUSED SPACE	0	0	0	0	0	194.04
194.05	07955	MOB	0	0	0	0	0	194.05
194.06	07956	FOUNDATION	0	0	0	0	0	194.06
194.07	07957	KNOX COUNTY HEALTH DEPT	0	0	0	0	0	194.07
194.08	07958	INDUSTRIAL HEALTH	0	0	0	0	0	194.08
194.09	07959	COMMUNITY MENTAL HEALTH CENTER	52,512	0	0	0	8,509,232	194.09
194.10	07951	BEIRHAUS BUILDING	1,081	0	0	0	0	194.10
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	915,927	4,764,188	5,961,365	0	1,375,269	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.053044	0.225701	7,546.031646	0.000000	0.079691	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	151,064	247,321	213,033	0	106,768	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.008749	0.011717	269.662025	0.000000	0.006187	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: 15-0042

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

Worksheet B-1

Date/Time Prepared:
5/24/2023 12:05 pm

Cost Center Description		INTERNS & RESIDENTS					
		SERVICES-SALARY & FRINGES (ASSIGNED TIME)	SERVICES-OTHER PRGM COSTS (ASSIGNED TIME)	PARAMED PRGM-RADIOLOGY (ASSIGNED TIME)	PARAMED PRGM-LAB (ASSIGNED TIME)		
		21.00	22.00	23.00	23.01		
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
4.01	00401	COMMUNICATIONS					4.01
4.02	00402	PURCHASING & RECEIVING					4.02
4.03	00403	REGISTRATION					4.03
4.04	00404	PATIENT ACCOUNTS					4.04
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
17.00	01700	SOCIAL SERVICE					17.00
17.01	01701	MENTAL HEALTH OH					17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	12,984				21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD		12,984			22.00
23.00	02300	PARAMED PRGM-RADIOLOGY			0		23.00
23.01	02301	PARAMED PRGM-LAB				100	23.01
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	3,819	3,819	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	322	322	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	1,304	1,304	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	41.00
43.00	04300	NURSERY	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
51.01	05101	ENDOSCOPY	184	184	0	0	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	56	56	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	298	298	0	0	55.00
60.00	06000	LABORATORY	0	0	0	100	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	123	123	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	251	251	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	0	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	2,251	2,251	0	0	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	194	194	0	0	76.01
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	77.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
90.01	04950	WOUND CLINIC	0	0	0	0	90.01
91.00	09100	EMERGENCY	905	905	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS							
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	96.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE			0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	9,707	9,707	0	100	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	713	713	0	0	192.00
192.01	19201	FP PETERSBURG	0	0	0	0	192.01

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0042

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

Worksheet B-1

Date/Time Prepared:
5/24/2023 12:05 pm

Cost Center Description			INTERNS & RESIDENTS		PARAMED PRGM-RADIOLOGY (ASSIGNED TIME)	PARAMED PRGM-LAB (ASSIGNED TIME)		
			SERVICES-SALARY & FRINGES (ASSIGNED TIME)	SERVICES-OTHER PRGM COSTS (ASSIGNED TIME)				
			21.00	22.00				
192.02	19202	PEDIATRICS	0	0	0	0		192.02
192.03	19203	WASHINGTON PRIMARY CARE	0	0	0	0		192.03
192.04	19204	FOHC	0	0	0	0		192.04
194.00	07950	COMMUNITY HEALTH SERVICES	0	0	0	0		194.00
194.01	07960	CCBHC GRANTS	0	0	0	0		194.01
194.02	07952	MARKETING AND PUBLIC RELATIONS	0	0	0	0		194.02
194.03	07953	MH RESIDENTIAL	0	0	0	0		194.03
194.04	07954	UNUSED SPACE	0	0	0	0		194.04
194.05	07955	MOB	0	0	0	0		194.05
194.06	07956	FOUNDATION	0	0	0	0		194.06
194.07	07957	KNOX COUNTY HEALTH DEPT	0	0	0	0		194.07
194.08	07958	INDUSTRIAL HEALTH	0	0	0	0		194.08
194.09	07959	COMMUNITY MENTAL HEALTH CENTER	2,564	2,564	0	0		194.09
194.10	07951	BEIRHAUS BUILDING	0	0	0	0		194.10
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	4,377,572	3,610,692	0	286,718		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	337.151263	278.087800	0.000000	2,867.180000		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	371,413	42,758	0	2,608		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	28.605437	3.293130	0.000000	26.080000		205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)			0	0		206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)			0.000000	0.000000		207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0042

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

Worksheet C
Part I
Date/Time Prepared:
5/24/2023 12:05 pm

Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
				Total Costs	Hospital			
					RCE Disallowance	Total Costs		PPS
1.00	2.00	3.00	4.00	5.00				
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	18,317,455		18,317,455	0	18,317,455	30.00
31.00	03100	INTENSIVE CARE UNIT	9,855,219		9,855,219	0	9,855,219	31.00
40.00	04000	SUBPROVIDER - IPF	5,584,202		5,584,202	0	5,584,202	40.00
41.00	04100	SUBPROVIDER - IRF	5,409,538		5,409,538	0	5,409,538	41.00
43.00	04300	NURSERY	780,712		780,712	0	780,712	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	7,412,017		7,412,017	10,548	7,422,565	50.00
51.00	05100	RECOVERY ROOM	0		0	0	0	51.00
51.01	05101	ENDOSCOPY	3,029,508		3,029,508	0	3,029,508	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,914,925		1,914,925	0	1,914,925	52.00
53.00	05300	ANESTHESIOLOGY	1,509,820		1,509,820	0	1,509,820	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,238,454		11,238,454	0	11,238,454	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	5,852,038		5,852,038	4,782	5,856,820	55.00
60.00	06000	LABORATORY	11,596,267		11,596,267	0	11,596,267	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0		0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	3,991,242	0	3,991,242	0	3,991,242	65.00
66.00	06600	PHYSICAL THERAPY	8,874,051	0	8,874,051	0	8,874,051	66.00
69.00	06900	ELECTROCARDIOLOGY	6,031,659		6,031,659	3,187	6,034,846	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	1,951,208		1,951,208	13,214	1,964,422	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,262,807		4,262,807	0	4,262,807	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,897,070		4,897,070	0	4,897,070	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	26,196,809		26,196,809	0	26,196,809	73.00
75.00	07500	ASC (NON-DISTINCT PART)	4,564,646		4,564,646	10,015	4,574,661	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0		0	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	628,908		628,908	0	628,908	76.01
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0		0	0	0	77.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	331,598		331,598	0	331,598	90.00
90.01	04950	WOUND CLINIC	1,544,351		1,544,351	0	1,544,351	90.01
91.00	09100	EMERGENCY	11,379,707		11,379,707	10,598	11,390,305	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	3,975,584		3,975,584	0	3,975,584	92.00
OTHER REIMBURSABLE COST CENTERS								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	231,822		231,822	0	231,822	96.00
101.00	10100	HOME HEALTH AGENCY	0		0	0	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0		0	0	0	102.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	1,692,437		1,692,437		1,692,437	116.00
200.00		Subtotal (see instructions)	163,054,054	0	163,054,054	52,344	163,106,398	200.00
201.00		Less Observation Beds	3,975,584		3,975,584		3,975,584	201.00
202.00		Total (see instructions)	159,078,470	0	159,078,470	52,344	159,130,814	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0042	Period: From 01/01/2022 To 12/31/2022	Worksheet C Part I Date/Time Prepared: 5/24/2023 12:05 pm
		Title XVIII	Hospital	PPS

Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
	Inpatient	Outpatient	Total (col. 6 + col. 7)			
	6.00	7.00	8.00			
9.00	10.00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	17,046,695		17,046,695	30.00
31.00	03100	INTENSIVE CARE UNIT	13,659,418		13,659,418	31.00
40.00	04000	SUBPROVIDER - IPF	8,693,397		8,693,397	40.00
41.00	04100	SUBPROVIDER - IRF	7,060,958		7,060,958	41.00
43.00	04300	NURSERY	1,224,276		1,224,276	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	11,764,792	27,627,191	39,391,983	50.00
51.00	05100	RECOVERY ROOM	0	0	0	51.00
51.01	05101	ENDOSCOPY	1,019,882	11,801,643	12,821,525	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	5,212,894	313,879	5,526,773	52.00
53.00	05300	ANESTHESIOLOGY	1,935,898	5,746,827	7,682,725	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	16,785,254	85,163,336	101,948,590	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	932,610	26,027,069	26,959,679	55.00
60.00	06000	LABORATORY	23,158,112	58,687,377	81,845,489	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	9,493,203	3,980,841	13,474,044	65.00
66.00	06600	PHYSICAL THERAPY	13,978,972	10,807,876	24,786,848	66.00
69.00	06900	ELECTROCARDIOLOGY	13,619,999	22,963,649	36,583,648	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	186,948	5,675,955	5,862,903	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,774,030	1,327,219	3,101,249	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,010,378	8,477,842	10,488,220	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	17,440,921	62,887,437	80,328,358	73.00
75.00	07500	ASC (NON-DISTINCT PART)	56,657	25,133,102	25,189,759	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	649,485	30,020	679,505	76.01
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	77.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	308	110,253	110,561	90.00
90.01	04950	WOUND CLINIC	31,059	4,633,986	4,665,045	90.01
91.00	09100	EMERGENCY	12,366,225	45,966,501	58,332,726	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,477,610	5,506,350	7,983,960	92.00
OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	370,407	370,407	96.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
116.00	11600	HOSPICE	0	2,810,651	2,810,651	116.00
200.00		Subtotal (see instructions)	182,579,981	416,049,411	598,629,392	200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)	182,579,981	416,049,411	598,629,392	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0042	Period: From 01/01/2022 To 12/31/2022	Worksheet C Part I Date/Time Prepared: 5/24/2023 12:05 pm
Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital PPS
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
40.00	04000 SUBPROVIDER - IPF			40.00
41.00	04100 SUBPROVIDER - IRF			41.00
43.00	04300 NURSERY			43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.188428		50.00
51.00	05100 RECOVERY ROOM	0.000000		51.00
51.01	05101 ENDOSCOPY	0.236283		51.01
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.346482		52.00
53.00	05300 ANESTHESIOLOGY	0.196521		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.110236		54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.217244		55.00
60.00	06000 LABORATORY	0.141685		60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.000000		63.00
65.00	06500 RESPIRATORY THERAPY	0.296217		65.00
66.00	06600 PHYSICAL THERAPY	0.358015		66.00
69.00	06900 ELECTROCARDIOLOGY	0.164960		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000		70.00
70.01	07001 NEURODIAGNOSTICS	0.335060		70.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1.374545		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.466911		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.326122		73.00
75.00	07500 ASC (NON-DISTINCT PART)	0.181608		75.00
76.00	03950 MH ANCILLARY OUTPATIENT	0.000000		76.00
76.01	03951 INPATIENT DIALYSIS	0.925538		76.01
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0.000000		77.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	2.999231		90.00
90.01	04950 WOUND CLINIC	0.331047		90.01
91.00	09100 EMERGENCY	0.195264		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.497946		92.00
OTHER REIMBURSABLE COST CENTERS				
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0.625858		96.00
101.00	10100 HOME HEALTH AGENCY			101.00
102.00	10200 OPIOID TREATMENT PROGRAM			102.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300 INTEREST EXPENSE			113.00
116.00	11600 HOSPICE			116.00
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: 15-0042

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

Worksheet C
Part I
Date/Time Prepared:
5/24/2023 12:05 pm

		Title XIX		Hospital		Cost
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
			Total Costs	RCE Disallowance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	18,317,455	18,317,455	0	18,317,455	30.00
31.00	03100 INTENSIVE CARE UNIT	9,855,219	9,855,219	0	9,855,219	31.00
40.00	04000 SUBPROVIDER - IPF	5,584,202	5,584,202	0	5,584,202	40.00
41.00	04100 SUBPROVIDER - IRF	5,409,538	5,409,538	0	5,409,538	41.00
43.00	04300 NURSERY	780,712	780,712	0	780,712	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	7,412,017	7,412,017	10,548	7,422,565	50.00
51.00	05100 RECOVERY ROOM	0	0	0	0	51.00
51.01	05101 ENDOSCOPY	3,029,508	3,029,508	0	3,029,508	51.01
52.00	05200 DELIVERY ROOM & LABOR ROOM	1,914,925	1,914,925	0	1,914,925	52.00
53.00	05300 ANESTHESIOLOGY	1,509,820	1,509,820	0	1,509,820	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	11,238,454	11,238,454	0	11,238,454	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	5,852,038	5,852,038	4,782	5,856,820	55.00
60.00	06000 LABORATORY	11,596,267	11,596,267	0	11,596,267	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00
65.00	06500 RESPIRATORY THERAPY	3,991,242	3,991,242	0	3,991,242	65.00
66.00	06600 PHYSICAL THERAPY	8,874,051	8,874,051	0	8,874,051	66.00
69.00	06900 ELECTROCARDIOLOGY	6,031,659	6,031,659	3,187	6,034,846	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
70.01	07001 NEURODIAGNOSTICS	1,951,208	1,951,208	13,214	1,964,422	70.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	4,262,807	4,262,807	0	4,262,807	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	4,897,070	4,897,070	0	4,897,070	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	26,196,809	26,196,809	0	26,196,809	73.00
75.00	07500 ASC (NON-DISTINCT PART)	4,564,646	4,564,646	10,015	4,574,661	75.00
76.00	03950 MH ANCILLARY OUTPATIENT	0	0	0	0	76.00
76.01	03951 INPATIENT DIALYSIS	628,908	628,908	0	628,908	76.01
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0	0	0	0	77.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	331,598	331,598	0	331,598	90.00
90.01	04950 WOUND CLINIC	1,544,351	1,544,351	0	1,544,351	90.01
91.00	09100 EMERGENCY	11,379,707	11,379,707	10,598	11,390,305	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	3,975,584	3,975,584	0	3,975,584	92.00
OTHER REIMBURSABLE COST CENTERS						
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	231,822	231,822	0	231,822	96.00
101.00	10100 HOME HEALTH AGENCY	0	0	0	0	101.00
102.00	10200 OPIOID TREATMENT PROGRAM	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300 INTEREST EXPENSE	0	0	0	0	113.00
116.00	11600 HOSPICE	1,692,437	1,692,437	0	1,692,437	116.00
200.00	Subtotal (see instructions)	163,054,054	163,054,054	52,344	163,106,398	200.00
201.00	Less Observation Beds	3,975,584	3,975,584	0	3,975,584	201.00
202.00	Total (see instructions)	159,078,470	159,078,470	52,344	159,130,814	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 15-0042		Period: From 01/01/2022 To 12/31/2022		Worksheet C Part I Date/Time Prepared: 5/24/2023 12:05 pm	
			Title XIX		Hospital		Cost	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio			
	Inpatient	Outpatient	Total (col. 6 + col. 7)					
	6.00	7.00	8.00				9.00	10.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	17,046,695		17,046,695			30.00
31.00	03100	INTENSIVE CARE UNIT	13,659,418		13,659,418			31.00
40.00	04000	SUBPROVIDER - IPF	8,693,397		8,693,397			40.00
41.00	04100	SUBPROVIDER - IRF	7,060,958		7,060,958			41.00
43.00	04300	NURSERY	1,224,276		1,224,276			43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	11,764,792	27,627,191	39,391,983	0.188161	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00
51.01	05101	ENDOSCOPY	1,019,882	11,801,643	12,821,525	0.236283	0.000000	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	5,212,894	313,879	5,526,773	0.346482	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	1,935,898	5,746,827	7,682,725	0.196521	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	16,785,254	85,163,336	101,948,590	0.110236	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	932,610	26,027,069	26,959,679	0.217066	0.000000	55.00
60.00	06000	LABORATORY	23,158,112	58,687,377	81,845,489	0.141685	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0.000000	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	9,493,203	3,980,841	13,474,044	0.296217	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	13,978,972	10,807,876	24,786,848	0.358015	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	13,619,999	22,963,649	36,583,648	0.164873	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
70.01	07001	NEURODIAGNOSTICS	186,948	5,675,955	5,862,903	0.332806	0.000000	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,774,030	1,327,219	3,101,249	1.374545	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,010,378	8,477,842	10,488,220	0.466911	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	17,440,921	62,887,437	80,328,358	0.326122	0.000000	73.00
75.00	07500	ASC (NON-DISTINCT PART)	56,657	25,133,102	25,189,759	0.181210	0.000000	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0	0.000000	0.000000	76.00
76.01	03951	INPATIENT DIALYSIS	649,485	30,020	679,505	0.925538	0.000000	76.01
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0.000000	0.000000	77.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	308	110,253	110,561	2.999231	0.000000	90.00
90.01	04950	WOUND CLINIC	31,059	4,633,986	4,665,045	0.331047	0.000000	90.01
91.00	09100	EMERGENCY	12,366,225	45,966,501	58,332,726	0.195083	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,477,610	5,506,350	7,983,960	0.497946	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	370,407	370,407	0.625858	0.000000	96.00
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0			102.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	2,810,651	2,810,651			116.00
200.00		Subtotal (see instructions)	182,579,981	416,049,411	598,629,392			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	182,579,981	416,049,411	598,629,392			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0042

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

Worksheet C
Part I
Date/Time Prepared:
5/24/2023 12:05 pm

Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
31.00	03100 INTENSIVE CARE UNIT				31.00
40.00	04000 SUBPROVIDER - IPF				40.00
41.00	04100 SUBPROVIDER - IRF				41.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.000000			50.00
51.00	05100 RECOVERY ROOM	0.000000			51.00
51.01	05101 ENDOSCOPY	0.000000			51.01
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000			52.00
53.00	05300 ANESTHESIOLOGY	0.000000			53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000			54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000			55.00
60.00	06000 LABORATORY	0.000000			60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.000000			63.00
65.00	06500 RESPIRATORY THERAPY	0.000000			65.00
66.00	06600 PHYSICAL THERAPY	0.000000			66.00
69.00	06900 ELECTROCARDIOLOGY	0.000000			69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000			70.00
70.01	07001 NEURODIAGNOSTICS	0.000000			70.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000			73.00
75.00	07500 ASC (NON-DISTINCT PART)	0.000000			75.00
76.00	03950 MH ANCILLARY OUTPATIENT	0.000000			76.00
76.01	03951 INPATIENT DIALYSIS	0.000000			76.01
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0.000000			77.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.000000			90.00
90.01	04950 WOUND CLINIC	0.000000			90.01
91.00	09100 EMERGENCY	0.000000			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000			92.00
OTHER REIMBURSABLE COST CENTERS					
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0.000000			96.00
101.00	10100 HOME HEALTH AGENCY				101.00
102.00	10200 OPIOID TREATMENT PROGRAM				102.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300 INTEREST EXPENSE				113.00
116.00	11600 HOSPICE				116.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 15-0042	Period: From 01/01/2022 To 12/31/2022	Worksheet D Part I Date/Time Prepared: 5/24/2023 12:05 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	
Title XVIII Hospital PPS							
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	2,556,000	0	2,556,000	12,431	205.61	30.00
31.00	INTENSIVE CARE UNIT	913,274		913,274	5,306	172.12	31.00
40.00	SUBPROVIDER - IPF	619,468	0	619,468	4,252	145.69	40.00
41.00	SUBPROVIDER - IRF	731,837	0	731,837	6,032	121.33	41.00
43.00	NURSERY	13,884		13,884	818	16.97	43.00
200.00	Total (lines 30 through 199)	4,834,463		4,834,463	28,839		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	4,796	986,106				
31.00	INTENSIVE CARE UNIT	2,370	407,924				
40.00	SUBPROVIDER - IPF	600	87,414				
41.00	SUBPROVIDER - IRF	4,655	564,791				
43.00	NURSERY	0	0				
200.00	Total (lines 30 through 199)	12,421	2,046,235				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 15-0042

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

Worksheet D
Part II
Date/Time Prepared:
5/24/2023 12:05 pm

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)	Hospital		Capital Costs (column 3 x column 4)	
					Inpatient Program Charges	PPS		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	972,586	39,391,983	0.024690	4,819,245	118,987	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0	51.00
51.01	05101	ENDOSCOPY	481,933	12,821,525	0.037588	444,477	16,707	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	40,829	5,526,773	0.007387	0	0	52.00
53.00	05300	ANESTHESIOLOGY	13,524	7,682,725	0.001760	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	906,602	101,948,590	0.008893	7,116,456	63,287	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	699,603	26,959,679	0.025950	116,769	3,030	55.00
60.00	06000	LABORATORY	404,798	81,845,489	0.004946	9,702,273	47,987	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0.000000	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	238,240	13,474,044	0.017681	3,015,640	53,320	65.00
66.00	06600	PHYSICAL THERAPY	1,087,688	24,786,848	0.043882	2,956,469	129,736	66.00
69.00	06900	ELECTROCARDIOLOGY	715,567	36,583,648	0.019560	5,987,140	117,108	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	288,066	5,862,903	0.049134	23,440	1,152	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	168,558	3,101,249	0.054352	741,746	40,315	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	117,130	10,488,220	0.011168	1,084,066	12,107	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	370,706	80,328,358	0.004615	6,534,067	30,155	73.00
75.00	07500	ASC (NON-DISTINCT PART)	133,950	25,189,759	0.005318	0	0	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0.000000	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	298,715	679,505	0.439607	348,408	153,163	76.01
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0.000000	0	0	77.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	84,459	110,561	0.763913	0	0	90.00
90.01	04950	WOUND CLINIC	124,556	4,665,045	0.026700	5,102	136	90.01
91.00	09100	EMERGENCY	1,059,075	58,332,726	0.018156	5,347,351	97,087	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	554,749	7,983,960	0.069483	1,523,987	105,891	92.00
OTHER REIMBURSABLE COST CENTERS								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	15,812	370,407	0.042688	0	0	96.00
200.00		Total (lines 50 through 199)	8,777,146	548,133,997		49,766,636	990,168	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0042	Period: From 01/01/2022 To 12/31/2022	Worksheet D Part III Date/Time Prepared: 5/24/2023 12:05 pm
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Cost Center Description		Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
		1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	41.00
43.00	04300	NURSERY	0	0	0	0	43.00
200.00		Total (lines 30 through 199)	0	0	0	0	200.00
Cost Center Description		Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
		4.00	5.00	6.00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	0	12,431	0.00	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	5,306	0.00	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	4,252	0.00	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	6,032	0.00	41.00
43.00	04300	NURSERY	0	0	818	0.00	43.00
200.00		Total (lines 30 through 199)	0	0	28,839		200.00
Cost Center Description		Inpatient Program Pass-Through Cost (col. 7 x col. 8)					
		9.00					
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0				30.00
31.00	03100	INTENSIVE CARE UNIT	0				31.00
40.00	04000	SUBPROVIDER - IPF	0				40.00
41.00	04100	SUBPROVIDER - IRF	0				41.00
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: 15-0042	Period: From 01/01/2022 To 12/31/2022	Worksheet D Part IV Date/Time Prepared: 5/24/2023 12:05 pm
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Cost Center Description	Title XVIII			Hospital		Allied Health Post-Stepdown Adjustments	Allied Health PPS	
	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments				
	1.00	2A	2.00	3A				
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
51.01	05101	ENDOSCOPY	0	0	0	0	0	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
60.00	06000	LABORATORY	0	0	0	0	286,718	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	0	0	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	0	0	0	0	0	76.01
77.00	07700	ALLOGENEIC HSCT 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	04950	WOUND CLINIC	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
200.00		Total (lines 50 through 199)	0	0	0	0	286,718	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0042

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

Worksheet D
Part IV
Date/Time Prepared:
5/24/2023 12:05 pm

Cost Center Description		Title XVIII			Hospital	PPS		
		All Other Medical Education Cost	Total Cost (sum of col. 1, 2, 3, and 4)	Total Outpatient Cost (sum of col. 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	39,391,983	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0.000000	51.00
51.01	05101	ENDOSCOPY	0	0	0	12,821,525	0.000000	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	5,526,773	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	7,682,725	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	101,948,590	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	26,959,679	0.000000	55.00
60.00	06000	LABORATORY	0	286,718	286,718	81,845,489	0.003503	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	13,474,044	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	24,786,848	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	36,583,648	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0.000000	70.00
70.01	07001	NEURODIAGNOSTICS	0	0	0	5,862,903	0.000000	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	3,101,249	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	10,488,220	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	80,328,358	0.000000	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	25,189,759	0.000000	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0	0	0.000000	76.00
76.01	03951	INPATIENT DIALYSIS	0	0	0	679,505	0.000000	76.01
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0.000000	77.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	110,561	0.000000	90.00
90.01	04950	WOUND CLINIC	0	0	0	4,665,045	0.000000	90.01
91.00	09100	EMERGENCY	0	0	0	58,332,726	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	7,983,960	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	370,407	0.000000	96.00
200.00		Total (lines 50 through 199)	0	286,718	286,718	548,133,997		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0042

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

Worksheet D
Part IV
Date/Time Prepared:
5/24/2023 12:05 pm

Cost Center Description		Title XVIII			Hospital		PPS
		Outpatient Ratio of Cost to Charges (col. 6 + col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0.000000	4,819,245	0	9,076,033	0	50.00
51.00	05100 RECOVERY ROOM	0.000000	0	0	0	0	51.00
51.01	05101 ENDOSCOPY	0.000000	444,477	0	3,859,232	0	51.01
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	12,184	0	52.00
53.00	05300 ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	7,116,456	0	28,126,595	0	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000	116,769	0	12,436,832	0	55.00
60.00	06000 LABORATORY	0.003503	9,702,273	33,987	6,905,798	24,191	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	0	0	63.00
65.00	06500 RESPIRATORY THERAPY	0.000000	3,015,640	0	1,285,772	0	65.00
66.00	06600 PHYSICAL THERAPY	0.000000	2,956,469	0	222,030	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	5,987,140	0	10,022,152	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
70.01	07001 NEURODIAGNOSTICS	0.000000	23,440	0	1,655,816	0	70.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	741,746	0	616,879	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	1,084,066	0	3,554,442	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	6,534,067	0	32,552,212	0	73.00
75.00	07500 ASC (NON-DISTINCT PART)	0.000000	0	0	6,562,521	0	75.00
76.00	03950 MH ANCILLARY OUTPATIENT	0.000000	0	0	0	0	76.00
76.01	03951 INPATIENT DIALYSIS	0.000000	348,408	0	10,936	0	76.01
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	0	0	77.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0.000000	0	0	0	0	90.00
90.01	04950 WOUND CLINIC	0.000000	5,102	0	2,096,581	0	90.01
91.00	09100 EMERGENCY	0.000000	5,347,351	0	9,458,494	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	1,523,987	0	902,289	0	92.00
OTHER REIMBURSABLE COST CENTERS							
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	0	0	96.00
200.00	Total (lines 50 through 199)		49,766,636	33,987	129,356,798	24,191	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 15-0042	Period: From 01/01/2022 To 12/31/2022	Worksheet D Part V Date/Time Prepared: 5/24/2023 12:05 pm
		Title XVIII	Hospital	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs			
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)			
	1.00	2.00	3.00	4.00	5.00			
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.188161	9,076,033	0	0	1,707,755	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
51.01	05101	ENDOSCOPY	0.236283	3,859,232	0	0	911,871	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.346482	12,184	0	0	4,222	52.00
53.00	05300	ANESTHESIOLOGY	0.196521	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.110236	28,126,595	0	0	3,100,563	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.217066	12,436,832	0	0	2,699,613	55.00
60.00	06000	LABORATORY	0.141685	6,905,798	0	0	978,448	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.296217	1,285,772	0	0	380,868	65.00
66.00	06600	PHYSICAL THERAPY	0.358015	222,030	0	0	79,490	66.00
69.00	06900	ELECTROCARDIOLOGY	0.164873	10,022,152	0	0	1,652,382	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	0.332806	1,655,816	0	0	551,065	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.374545	616,879	0	0	847,928	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.466911	3,554,442	0	0	1,659,608	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.326122	32,552,212	0	25,452	10,615,992	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.181210	6,562,521	0	0	1,189,194	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0.000000	0	0	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	0.925538	10,936	0	0	10,122	76.01
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	0	0	77.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	2.999231	0	0	0	0	90.00
90.01	04950	WOUND CLINIC	0.331047	2,096,581	0	0	694,067	90.01
91.00	09100	EMERGENCY	0.195083	9,458,494	0	79	1,845,191	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.497946	902,289	0	0	449,291	92.00
OTHER REIMBURSABLE COST CENTERS								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.625858	0	0	0	0	96.00
200.00		Subtotal (see instructions)		129,356,798	0	25,531	29,377,670	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		129,356,798	0	25,531	29,377,670	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0042	Period: From 01/01/2022 To 12/31/2022	Worksheet D Part V Date/Time Prepared: 5/24/2023 12:05 pm
Title XVIII		Hospital	PPS

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0	0		50.00
51.00 05100 RECOVERY ROOM	0	0		51.00
51.01 05101 ENDOSCOPY	0	0		51.01
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00 05300 ANESTHESIOLOGY	0	0		53.00
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
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
65.00 06500 RESPIRATORY THERAPY	0	0		65.00
66.00 06600 PHYSICAL THERAPY	0	0		66.00
69.00 06900 ELECTROCARDIOLOGY	0	0		69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		70.00
70.01 07001 NEURODIAGNOSTICS	0	0		70.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	8,300		73.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0		75.00
76.00 03950 MH ANCILLARY OUTPATIENT	0	0		76.00
76.01 03951 INPATIENT DIALYSIS	0	0		76.01
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0		77.00
OUTPATIENT SERVICE COST CENTERS				
90.00 09000 CLINIC	0	0		90.00
90.01 04950 WOUND CLINIC	0	0		90.01
91.00 09100 EMERGENCY	0	15		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
OTHER REIMBURSABLE COST CENTERS				
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0		96.00
200.00 Subtotal (see instructions)	0	8,315		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00 Net Charges (line 200 - line 201)	0	8,315		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 15-0042 Component CCN: 15-S042	Period: From 01/01/2022 To 12/31/2022	Worksheet D Part II Date/Time Prepared: 5/24/2023 12:05 pm
Title XVIII			Subprovider - IPF	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	972,586	39,391,983	0.024690	19,636	485	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0	51.00
51.01	05101	ENDOSCOPY	481,933	12,821,525	0.037588	0	0	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	40,829	5,526,773	0.007387	0	0	52.00
53.00	05300	ANESTHESIOLOGY	13,524	7,682,725	0.001760	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	906,602	101,948,590	0.008893	41,812	372	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	699,603	26,959,679	0.025950	827	21	55.00
60.00	06000	LABORATORY	404,798	81,845,489	0.004946	167,800	830	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0.000000	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	238,240	13,474,044	0.017681	70,395	1,245	65.00
66.00	06600	PHYSICAL THERAPY	1,087,688	24,786,848	0.043882	14,518	637	66.00
69.00	06900	ELECTROCARDIOLOGY	715,567	36,583,648	0.019560	13,356	261	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	288,066	5,862,903	0.049134	6,804	334	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	168,558	3,101,249	0.054352	1,422	77	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	117,130	10,488,220	0.011168	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	370,706	80,328,358	0.004615	100,909	466	73.00
75.00	07500	ASC (NON-DISTINCT PART)	133,950	25,189,759	0.005318	0	0	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0.000000	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	298,715	679,505	0.439607	0	0	76.01
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0.000000	0	0	77.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	84,459	110,561	0.763913	0	0	90.00
90.01	04950	WOUND CLINIC	124,556	4,665,045	0.026700	0	0	90.01
91.00	09100	EMERGENCY	1,059,075	58,332,726	0.018156	185,041	3,360	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	7,983,960	0.000000	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	15,812	370,407	0.042688	0	0	96.00
200.00		Total (lines 50 through 199)	8,222,397	548,133,997		622,520	8,088	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0042 Component CCN: 15-S042	Period: From 01/01/2022 To 12/31/2022	Worksheet D Part IV Date/Time Prepared: 5/24/2023 12:05 pm
Title XVIII		Subprovider - IPF	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
51.00	05100 RECOVERY ROOM	0	0	0	0	0	51.00
51.01	05101 ENDOSCOPY	0	0	0	0	0	51.01
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
60.00	06000 LABORATORY	0	0	0	0	286,718	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	07001 NEURODIAGNOSTICS	0	0	0	0	0	70.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	07500 ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	03950 MH ANCILLARY OUTPATIENT	0	0	0	0	0	76.00
76.01	03951 INPATIENT DIALYSIS	0	0	0	0	0	76.01
77.00	07700 ALLOGENEIC HSCT 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	04950 WOUND CLINIC	0	0	0	0	0	90.01
91.00	09100 EMERGENCY	0	0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
200.00	Total (lines 50 through 199)	0	0	0	0	286,718	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0042 Component CCN: 15-S042	Period: From 01/01/2022 To 12/31/2022	Worksheet D Part IV Date/Time Prepared: 5/24/2023 12:05 pm
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Cost Center Description		All Other Medical Education Cost	Total Cost (sum of col s. 1, 2, 3, and 4)	Total Outpatient Cost (sum of col s. 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	39,391,983	0.000000	50.00
51.00	05100 RECOVERY ROOM	0	0	0	0	0.000000	51.00
51.01	05101 ENDOSCOPY	0	0	0	12,821,525	0.000000	51.01
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	5,526,773	0.000000	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	7,682,725	0.000000	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	101,948,590	0.000000	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	0	26,959,679	0.000000	55.00
60.00	06000 LABORATORY	0	286,718	286,718	81,845,489	0.003503	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0.000000	63.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	13,474,044	0.000000	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	24,786,848	0.000000	66.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	36,583,648	0.000000	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0.000000	70.00
70.01	07001 NEURODIAGNOSTICS	0	0	0	5,862,903	0.000000	70.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	3,101,249	0.000000	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	10,488,220	0.000000	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	80,328,358	0.000000	73.00
75.00	07500 ASC (NON-DISTINCT PART)	0	0	0	25,189,759	0.000000	75.00
76.00	03950 MH ANCILLARY OUTPATIENT	0	0	0	0	0.000000	76.00
76.01	03951 INPATIENT DIALYSIS	0	0	0	679,505	0.000000	76.01
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0.000000	77.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	0	0	110,561	0.000000	90.00
90.01	04950 WOUND CLINIC	0	0	0	4,665,045	0.000000	90.01
91.00	09100 EMERGENCY	0	0	0	58,332,726	0.000000	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	7,983,960	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS							
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	370,407	0.000000	96.00
200.00	Total (lines 50 through 199)	0	286,718	286,718	548,133,997		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 15-0042 Component CCN: 15-S042	Period: From 01/01/2022 To 12/31/2022	Worksheet D Part IV Date/Time Prepared: 5/24/2023 12:05 pm			
Cost Center Description			Title XVIII		Subprovider - IPF	PPS	
		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.000000	19,636	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	51.00
51.01	05101	ENDOSCOPY	0.000000	0	0	0	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	41,812	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	827	0	0	55.00
60.00	06000	LABORATORY	0.003503	167,800	588	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.000000	70,395	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	14,518	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	13,356	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	0.000000	6,804	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	1,422	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	100,909	0	223	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	0	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0.000000	0	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	0.000000	0	0	0	76.01
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	0	77.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0.000000	0	0	0	90.00
90.01	04950	WOUND CLINIC	0.000000	0	0	0	90.01
91.00	09100	EMERGENCY	0.000000	185,041	0	393	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	0	96.00
200.00		Total (lines 50 through 199)		622,520	588	616	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 15-0042 Component CCN: 15-S042	Period: From 01/01/2022 To 12/31/2022	Worksheet D Part V Date/Time Prepared: 5/24/2023 12:05 pm
		Title XVIII	Subprovider - IPF	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	PPS Services (see inst.)
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
		1.00	2.00	3.00	4.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0.188161	0	0	0	0	50.00
51.00 05100 RECOVERY ROOM	0.000000	0	0	0	0	51.00
51.01 05101 ENDOSCOPY	0.236283	0	0	0	0	51.01
52.00 05200 DELIVERY ROOM & LABOR ROOM	0.346482	0	0	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0.196521	0	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.110236	0	0	0	0	54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	0.217066	0	0	0	0	55.00
60.00 06000 LABORATORY	0.141685	0	0	0	0	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	0	0	63.00
65.00 06500 RESPIRATORY THERAPY	0.296217	0	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0.358015	0	0	0	0	66.00
69.00 06900 ELECTROCARDIOLOGY	0.164873	0	0	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
70.01 07001 NEURODIAGNOSTICS	0.332806	0	0	0	0	70.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1.374545	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.466911	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.326122	223	0	105	73	73.00
75.00 07500 ASC (NON-DISTINCT PART)	0.181210	0	0	0	0	75.00
76.00 03950 MH ANCILLARY OUTPATIENT	0.000000	0	0	0	0	76.00
76.01 03951 INPATIENT DIALYSIS	0.925538	0	0	0	0	76.01
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	0	0	77.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	2.999231	0	0	0	0	90.00
90.01 04950 WOUND CLINIC	0.331047	0	0	0	0	90.01
91.00 09100 EMERGENCY	0.195083	393	0	0	77	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.497946	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0.625858	0	0	0	0	96.00
200.00	Subtotal (see instructions)		616	0	105	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00	Net Charges (line 200 - line 201)		616	0	105	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0042 Component CCN: 15-S042	Period: From 01/01/2022 To 12/31/2022	Worksheet D Part V Date/Time Prepared: 5/24/2023 12:05 pm
	Title XVIII	Subprovider - IPF	PPS

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0	0		50.00
51.00 05100 RECOVERY ROOM	0	0		51.00
51.01 05101 ENDOSCOPY	0	0		51.01
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00 05300 ANESTHESIOLOGY	0	0		53.00
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
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
65.00 06500 RESPIRATORY THERAPY	0	0		65.00
66.00 06600 PHYSICAL THERAPY	0	0		66.00
69.00 06900 ELECTROCARDIOLOGY	0	0		69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		70.00
70.01 07001 NEURODIAGNOSTICS	0	0		70.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	34		73.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0		75.00
76.00 03950 MH ANCILLARY OUTPATIENT	0	0		76.00
76.01 03951 INPATIENT DIALYSIS	0	0		76.01
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0		77.00
OUTPATIENT SERVICE COST CENTERS				
90.00 09000 CLINIC	0	0		90.00
90.01 04950 WOUND CLINIC	0	0		90.01
91.00 09100 EMERGENCY	0	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
OTHER REIMBURSABLE COST CENTERS				
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0		96.00
200.00 Subtotal (see instructions)	0	34		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00 Net Charges (line 200 - line 201)	0	34		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 15-0042 Component CCN: 15-T042	Period: From 01/01/2022 To 12/31/2022	Worksheet D Part II Date/Time Prepared: 5/24/2023 12:05 pm
Title XVIII			Subprovider - IRF	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	972,586	39,391,983	0.024690	53,957	1,332	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0	51.00
51.01	05101	ENDOSCOPY	481,933	12,821,525	0.037588	13,236	498	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	40,829	5,526,773	0.007387	0	0	52.00
53.00	05300	ANESTHESIOLOGY	13,524	7,682,725	0.001760	502	1	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	906,602	101,948,590	0.008893	433,221	3,853	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	699,603	26,959,679	0.025950	0	0	55.00
60.00	06000	LABORATORY	404,798	81,845,489	0.004946	961,935	4,758	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0.000000	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	238,240	13,474,044	0.017681	1,153,723	20,399	65.00
66.00	06600	PHYSICAL THERAPY	1,087,688	24,786,848	0.043882	6,660,215	292,264	66.00
69.00	06900	ELECTROCARDIOLOGY	715,567	36,583,648	0.019560	80,351	1,572	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
70.01	07001	NEURODIAGNOSTICS	288,066	5,862,903	0.049134	10,830	532	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	168,558	3,101,249	0.054352	147,289	8,005	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	117,130	10,488,220	0.011168	14,336	160	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	370,706	80,328,358	0.004615	1,066,667	4,923	73.00
75.00	07500	ASC (NON-DISTINCT PART)	133,950	25,189,759	0.005318	0	0	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0	0	0.000000	0	0	76.00
76.01	03951	INPATIENT DIALYSIS	298,715	679,505	0.439607	77,919	34,254	76.01
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0.000000	0	0	77.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	84,459	110,561	0.763913	308	235	90.00
90.01	04950	WOUND CLINIC	124,556	4,665,045	0.026700	0	0	90.01
91.00	09100	EMERGENCY	1,059,075	58,332,726	0.018156	41,678	757	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	7,983,960	0.000000	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	15,812	370,407	0.042688	0	0	96.00
200.00		Total (lines 50 through 199)	8,222,397	548,133,997		10,716,167	373,543	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0042 Component CCN: 15-T042	Period: From 01/01/2022 To 12/31/2022	Worksheet D Part IV Date/Time Prepared: 5/24/2023 12:05 pm
Title XVIII		Subprovider - IRF	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
51.00	05100 RECOVERY ROOM	0	0	0	0	0	51.00
51.01	05101 ENDOSCOPY	0	0	0	0	0	51.01
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
60.00	06000 LABORATORY	0	0	0	0	286,718	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	07001 NEURODIAGNOSTICS	0	0	0	0	0	70.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	07500 ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	03950 MH ANCILLARY OUTPATIENT	0	0	0	0	0	76.00
76.01	03951 INPATIENT DIALYSIS	0	0	0	0	0	76.01
77.00	07700 ALLOGENEIC HSCT 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	04950 WOUND CLINIC	0	0	0	0	0	90.01
91.00	09100 EMERGENCY	0	0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
200.00	Total (lines 50 through 199)	0	0	0	0	286,718	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0042 Component CCN: 15-T042	Period: From 01/01/2022 To 12/31/2022	Worksheet D Part IV Date/Time Prepared: 5/24/2023 12:05 pm
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Cost Center Description		All Other Medical Education Cost	Total Cost (sum of col s. 1, 2, 3, and 4)	Total Outpatient Cost (sum of col s. 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	39,391,983	0.000000	50.00
51.00	05100 RECOVERY ROOM	0	0	0	0	0.000000	51.00
51.01	05101 ENDOSCOPY	0	0	0	12,821,525	0.000000	51.01
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	5,526,773	0.000000	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	7,682,725	0.000000	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	101,948,590	0.000000	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	0	26,959,679	0.000000	55.00
60.00	06000 LABORATORY	0	286,718	286,718	81,845,489	0.003503	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0.000000	63.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	13,474,044	0.000000	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	24,786,848	0.000000	66.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	36,583,648	0.000000	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0.000000	70.00
70.01	07001 NEURODIAGNOSTICS	0	0	0	5,862,903	0.000000	70.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	3,101,249	0.000000	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	10,488,220	0.000000	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	80,328,358	0.000000	73.00
75.00	07500 ASC (NON-DISTINCT PART)	0	0	0	25,189,759	0.000000	75.00
76.00	03950 MH ANCILLARY OUTPATIENT	0	0	0	0	0.000000	76.00
76.01	03951 INPATIENT DIALYSIS	0	0	0	679,505	0.000000	76.01
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0.000000	77.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	0	0	110,561	0.000000	90.00
90.01	04950 WOUND CLINIC	0	0	0	4,665,045	0.000000	90.01
91.00	09100 EMERGENCY	0	0	0	58,332,726	0.000000	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	7,983,960	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS							
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	370,407	0.000000	96.00
200.00	Total (lines 50 through 199)	0	286,718	286,718	548,133,997		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 15-0042 Component CCN: 15-T042	Period: From 01/01/2022 To 12/31/2022	Worksheet D Part IV Date/Time Prepared: 5/24/2023 12:05 pm		
Title XVIII			Subprovider - IRF	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	53,957	0	0	0	50.00
51.00 05100 RECOVERY ROOM	0.000000	0	0	0	0	51.00
51.01 05101 ENDOSCOPY	0.000000	13,236	0	0	0	51.01
52.00 05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0.000000	502	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.000000	433,221	0	5,954	0	54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	55.00
60.00 06000 LABORATORY	0.003503	961,935	3,370	1,307	5	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	0	0	63.00
65.00 06500 RESPIRATORY THERAPY	0.000000	1,153,723	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0.000000	6,660,215	0	0	0	66.00
69.00 06900 ELECTROCARDIOLOGY	0.000000	80,351	0	315	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
70.01 07001 NEURODIAGNOSTICS	0.000000	10,830	0	0	0	70.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	147,289	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	14,336	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.000000	1,066,667	0	245	0	73.00
75.00 07500 ASC (NON-DISTINCT PART)	0.000000	0	0	0	0	75.00
76.00 03950 MH ANCILLARY OUTPATIENT	0.000000	0	0	0	0	76.00
76.01 03951 INPATIENT DIALYSIS	0.000000	77,919	0	0	0	76.01
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	0	0	77.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	0.000000	308	0	707	0	90.00
90.01 04950 WOUND CLINIC	0.000000	0	0	0	0	90.01
91.00 09100 EMERGENCY	0.000000	41,678	0	1,907	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	0	0	96.00
200.00	Total (lines 50 through 199)	10,716,167	3,370	10,435	5	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0042 Component CCN: 15-T042	Period: From 01/01/2022 To 12/31/2022	Worksheet D Part V Date/Time Prepared: 5/24/2023 12:05 pm
Title XVIII		Subprovider - IRF	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	PPS Services (see inst.)	
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
		1.00	2.00	3.00	4.00		5.00
ANCILLARY SERVICE COST CENTERS							
50.00 05000 OPERATING ROOM	0.188161	0	0	0	0	50.00	
51.00 05100 RECOVERY ROOM	0.000000	0	0	0	0	51.00	
51.01 05101 ENDOSCOPY	0.236283	0	0	0	0	51.01	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0.346482	0	0	0	0	52.00	
53.00 05300 ANESTHESIOLOGY	0.196521	0	0	0	0	53.00	
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.110236	5,954	0	0	656	54.00	
55.00 05500 RADIOLOGY-THERAPEUTIC	0.217066	0	0	0	0	55.00	
60.00 06000 LABORATORY	0.141685	1,307	0	0	185	60.00	
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	0	0	63.00	
65.00 06500 RESPIRATORY THERAPY	0.296217	0	0	0	0	65.00	
66.00 06600 PHYSICAL THERAPY	0.358015	0	0	0	0	66.00	
69.00 06900 ELECTROCARDIOLOGY	0.164873	315	0	0	52	69.00	
70.00 07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00	
70.01 07001 NEURODIAGNOSTICS	0.332806	0	0	0	0	70.01	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1.374545	0	0	0	0	71.00	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.466911	0	0	0	0	72.00	
73.00 07300 DRUGS CHARGED TO PATIENTS	0.326122	245	0	751	80	73.00	
75.00 07500 ASC (NON-DISTINCT PART)	0.181210	0	0	0	0	75.00	
76.00 03950 MH ANCILLARY OUTPATIENT	0.000000	0	0	0	0	76.00	
76.01 03951 INPATIENT DIALYSIS	0.925538	0	0	0	0	76.01	
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	0	0	77.00	
OUTPATIENT SERVICE COST CENTERS							
90.00 09000 CLINIC	2.999231	707	0	0	2,120	90.00	
90.01 04950 WOUND CLINIC	0.331047	0	0	0	0	90.01	
91.00 09100 EMERGENCY	0.195083	1,907	0	0	372	91.00	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.497946	0	0	0	0	92.00	
OTHER REIMBURSABLE COST CENTERS							
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0.625858	0	0	0	0	96.00	
200.00	Subtotal (see instructions)		10,435	0	751	3,465	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00	Net Charges (Line 200 - Line 201)		10,435	0	751	3,465	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0042 Component CCN: 15-T042	Period: From 01/01/2022 To 12/31/2022	Worksheet D Part V Date/Time Prepared: 5/24/2023 12:05 pm
	Title XVIII	Subprovider - IRF	PPS

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0	0		50.00
51.00 05100 RECOVERY ROOM	0	0		51.00
51.01 05101 ENDOSCOPY	0	0		51.01
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00 05300 ANESTHESIOLOGY	0	0		53.00
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
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
65.00 06500 RESPIRATORY THERAPY	0	0		65.00
66.00 06600 PHYSICAL THERAPY	0	0		66.00
69.00 06900 ELECTROCARDIOLOGY	0	0		69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		70.00
70.01 07001 NEURODIAGNOSTICS	0	0		70.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	245		73.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0		75.00
76.00 03950 MH ANCILLARY OUTPATIENT	0	0		76.00
76.01 03951 INPATIENT DIALYSIS	0	0		76.01
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0		77.00
OUTPATIENT SERVICE COST CENTERS				
90.00 09000 CLINIC	0	0		90.00
90.01 04950 WOUND CLINIC	0	0		90.01
91.00 09100 EMERGENCY	0	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
OTHER REIMBURSABLE COST CENTERS				
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0		96.00
200.00 Subtotal (see instructions)	0	245		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00 Net Charges (line 200 - line 201)	0	245		202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0042	Period: From 01/01/2022 To 12/31/2022	Worksheet D-1 Date/Time Prepared: 5/24/2023 12:05 pm
Cost Center Description		Title XVIII	Hospital	PPS
		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		12,431	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		12,431	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)		9,733	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)		4,796	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)		18,317,455	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)		18,317,455	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)		18,317,455	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)		1,473.53	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		7,067,050	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)		7,067,050	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0042		Period: From 01/01/2022 To 12/31/2022		Worksheet D-1	
		Title XVIII		Hospital		PPS	
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	9,855,219	5,306	1,857.37	2,370	4,401,967	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					11,928,654	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)					23,397,671	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)					1,394,030	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					1,024,155	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					2,418,185	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthesiologist, and medical education costs (line 49 minus line 52)					20,979,486	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)					2,698	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,473.53	88.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0042		Period: From 01/01/2022 To 12/31/2022		Worksheet D-1 Date/Time Prepared: 5/24/2023 12:05 pm	
Title XVIII		Hospital		PPS			
Cost Center Description						1.00	
89.00	Observation bed cost (line 87 x line 88) (see instructions)					3,975,584	89.00
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	2,556,000	18,317,455	0.139539	3,975,584	554,749	90.00
91.00	Nursing Program cost	0	18,317,455	0.000000	3,975,584	0	91.00
92.00	Allied health cost	0	18,317,455	0.000000	3,975,584	0	92.00
93.00	All other Medical Education	0	18,317,455	0.000000	3,975,584	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0042	Period: From 01/01/2022 To 12/31/2022	Worksheet D-1
		Component CCN: 15-S042		Date/Time Prepared: 5/24/2023 12:05 pm
		Title XVIII	Subprovider - IPF	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)		4,252	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		4,252	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)		4,252	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)		600	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)		5,584,202	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)		5,584,202	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)		5,584,202	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)		1,313.31	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		787,986	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)		787,986	41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 15-0042	Period: From 01/01/2022 To 12/31/2022	Worksheet D-1	
				Component CCN: 15-S042	Date/Time Prepared: 5/24/2023 12:05 pm		
				Title XVIII	Subprovider - IPF	PPS	
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	0	0	0.00	0	0	43.00	
44.00 CORONARY CARE UNIT						44.00	
45.00 BURN INTENSIVE CARE UNIT						45.00	
46.00 SURGICAL INTENSIVE CARE UNIT						46.00	
47.00 OTHER SPECIAL CARE (SPECIFY)						47.00	
Cost Center Description					1.00		
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					133,793	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)					921,779	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)					87,414	50.00	
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					8,676	51.00	
52.00 Total Program excludable cost (sum of lines 50 and 51)					96,090	52.00	
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					825,689	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)					0	87.00	

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0042 Component CCN: 15-S042		Period: From 01/01/2022 To 12/31/2022		Worksheet D-1 Date/Time Prepared: 5/24/2023 12:05 pm		
		Title XVIII		Subprovider - IPF		PPS		
Cost Center Description								
						1.00		
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)						0	89.00
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	619,468	5,584,202	0.110932	0	0	90.00	
91.00	Nursing Program cost	0	5,584,202	0.000000	0	0	91.00	
92.00	Allied health cost	0	5,584,202	0.000000	0	0	92.00	
93.00	All other Medical Education	0	5,584,202	0.000000	0	0	93.00	

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0042 Component CCN: 15-T042	Period: From 01/01/2022 To 12/31/2022	Worksheet D-1 Date/Time Prepared: 5/24/2023 12:05 pm
		Title XVIII	Subprovider - IRF	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)		6,032	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		6,032	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)		6,032	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		4,655	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)		5,409,538	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)		5,409,538	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)		5,409,538	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)		896.81	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		4,174,651	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)		4,174,651	41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 15-0042	Period: From 01/01/2022 To 12/31/2022	Worksheet D-1
				Component CCN: 15-T042		Date/Time Prepared: 5/24/2023 12:05 pm
				Title XVIII	Subprovider - IRF	PPS
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	0	0	0.00	0	0	43.00
44.00 CORONARY CARE UNIT						44.00
45.00 BURN INTENSIVE CARE UNIT						45.00
46.00 SURGICAL INTENSIVE CARE UNIT						46.00
47.00 OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description					1.00	
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					3,578,727	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)					7,753,378	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)					564,791	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					376,913	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					941,704	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					6,811,674	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)					0	87.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0042 Component CCN: 15-T042		Period: From 01/01/2022 To 12/31/2022		Worksheet D-1 Date/Time Prepared: 5/24/2023 12:05 pm	
		Title XVIII		Subprovider - IRF		PPS	
Cost Center Description						1.00	
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					0	89.00
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	731,837	5,409,538	0.135286	0	0	90.00
91.00	Nursing Program cost	0	5,409,538	0.000000	0	0	91.00
92.00	Allied health cost	0	5,409,538	0.000000	0	0	92.00
93.00	All other Medical Education	0	5,409,538	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0042	Period: From 01/01/2022 To 12/31/2022	Worksheet D-1
		Title XIX	Hospital	Date/Time Prepared: 5/24/2023 12:05 pm
Cost Center Description			Cost	
			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		12,431	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		12,431	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)		9,733	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)		548	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)		818	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)		18,317,455	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)		18,317,455	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)		18,317,455	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)		1,473.53	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		807,494	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)		807,494	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 15-0042	Period: From 01/01/2022 To 12/31/2022	Worksheet D-1 Date/Time Prepared: 5/24/2023 12:05 pm
Title XIX			Hospital	Cost	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
	1.00	2.00	3.00	4.00	5.00
42.00 NURSERY (title V & XIX only)	780,712	818	954.42	0	0
Intensive Care Type Inpatient Hospital Units					
43.00 INTENSIVE CARE UNIT	9,855,219	5,306	1,857.37	0	0
44.00 CORONARY CARE UNIT					
45.00 BURN INTENSIVE CARE UNIT					
46.00 SURGICAL INTENSIVE CARE UNIT					
47.00 OTHER SPECIAL CARE (SPECIFY)					
Cost Center Description					
					1.00
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					337,965
48.01 Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)					0
49.00 Total Program inpatient costs (sum of lines 41 through 48.01)(see instructions)					1,145,459
PASS THROUGH COST ADJUSTMENTS					
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0
52.00 Total Program excludable cost (sum of lines 50 and 51)					0
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthesiologist, and medical education costs (line 49 minus line 52)					0
TARGET AMOUNT AND LIMIT COMPUTATION					
54.00 Program discharges					0
55.00 Target amount per discharge					0.00
55.01 Permanent adjustment amount per discharge					0.00
55.02 Adjustment amount per discharge (contractor use only)					0.00
56.00 Target amount (line 54 x sum of lines 55, 55.01, and 55.02)					0
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0
58.00 Bonus payment (see instructions)					0
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
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
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
62.00 Relief payment (see instructions)					0
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0
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
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only): for CAH, see instructions					0
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
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
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0
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)					2,698
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,473.53

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0042		Period: From 01/01/2022 To 12/31/2022		Worksheet D-1 Date/Time Prepared: 5/24/2023 12:05 pm	
Cost Center Description		Title XIX		Hospital		Cost	
Cost Center Description						1.00	
89.00	Observation bed cost (line 87 x line 88) (see instructions)					3,975,584	89.00
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	2,556,000	18,317,455	0.139539	3,975,584	554,749	90.00
91.00	Nursing Program cost	0	18,317,455	0.000000	3,975,584	0	91.00
92.00	Allied health cost	0	18,317,455	0.000000	3,975,584	0	92.00
93.00	All other Medical Education	0	18,317,455	0.000000	3,975,584	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0042 Component CCN: 15-S042	Period: From 01/01/2022 To 12/31/2022	Worksheet D-1 Date/Time Prepared: 5/24/2023 12:05 pm
		Title XIX	Subprovider - IPF	Cost
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			4,252 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			4,252 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)			4,252 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)			214 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)			818 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)			5,584,202 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)			5,584,202 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)			5,584,202 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)			1,313.31 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			281,048 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)			281,048 41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 15-0042	Period: From 01/01/2022 To 12/31/2022	Worksheet D-1	
				Component CCN: 15-S042		Date/Time Prepared: 5/24/2023 12:05 pm	
				Title XIX	Subprovider - IPF	Cost	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00	
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00	
44.00 CORONARY CARE UNIT						44.00	
45.00 BURN INTENSIVE CARE UNIT						45.00	
46.00 SURGICAL INTENSIVE CARE UNIT						46.00	
47.00 OTHER SPECIAL CARE (SPECIFY)						47.00	
Cost Center Description					1.00		
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					37,948	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)					318,996	49.00	
PASS THROUGH COST ADJUSTMENTS							
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						0	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						0	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)						0	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00 Program discharges						0	54.00
55.00 Target amount per discharge					0.00	55.00	
55.01 Permanent adjustment amount per discharge					0.00	55.01	
55.02 Adjustment amount per discharge (contractor use only)					0.00	55.02	
56.00 Target amount (line 54 x sum of lines 55, 55.01, and 55.02)						0	56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						0	57.00
58.00 Bonus payment (see instructions)						0	58.00
59.00 Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)						0.00	59.00
60.00 Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)						0.00	60.00
61.00 Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)						0	61.00
62.00 Relief payment (see instructions)						0	62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)						0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)						0	64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						0	65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions						0	66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						0	67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						0	68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)							70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00 Program routine service cost (line 9 x line 71)							72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)							75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00 Program capital-related costs (line 9 x line 76)							77.00
78.00 Inpatient routine service cost (line 74 minus line 77)							78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00 Inpatient routine service cost per diem limitation							81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00 Reasonable inpatient routine service costs (see instructions)							83.00
84.00 Program inpatient ancillary services (see instructions)							84.00
85.00 Utilization review - physician compensation (see instructions)							85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)							86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00 Total observation bed days (see instructions)						0	87.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0042 Component CCN: 15-S042		Period: From 01/01/2022 To 12/31/2022		Worksheet D-1 Date/Time Prepared: 5/24/2023 12:05 pm	
		Title XIX		Subprovider - IPF		Cost	
Cost Center Description						1.00	
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					0	89.00
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	619,468	5,584,202	0.110932	0	0	90.00
91.00	Nursing Program cost	0	5,584,202	0.000000	0	0	91.00
92.00	Allied health cost	0	5,584,202	0.000000	0	0	92.00
93.00	All other Medical Education	0	5,584,202	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0042 Component CCN: 15-T042	Period: From 01/01/2022 To 12/31/2022	Worksheet D-1 Date/Time Prepared: 5/24/2023 12:05 pm
		Title XIX	Subprovider - IRF	Cost
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			6,032 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			6,032 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)			6,032 4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			0 5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			0 7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)			27 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)			818 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)			5,409,538 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)			5,409,538 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)			5,409,538 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)			896.81 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			24,214 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)			24,214 41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 15-0042	Period: From 01/01/2022 To 12/31/2022	Worksheet D-1	
				Component CCN: 15-T042	Date/Time Prepared: 5/24/2023 12:05 pm		
				Title XIX	Subprovider - IRF	Cost	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0	0	43.00
44.00 CORONARY CARE UNIT							44.00
45.00 BURN INTENSIVE CARE UNIT							45.00
46.00 SURGICAL INTENSIVE CARE UNIT							46.00
47.00 OTHER SPECIAL CARE (SPECIFY)							47.00
Cost Center Description					1.00		
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					1,467		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)					25,681		49.00
PASS THROUGH COST ADJUSTMENTS							
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						0	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						0	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)						0	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00 Program discharges						0	54.00
55.00 Target amount per discharge					0.00		55.00
55.01 Permanent adjustment amount per discharge					0.00		55.01
55.02 Adjustment amount per discharge (contractor use only)					0.00		55.02
56.00 Target amount (line 54 x sum of lines 55, 55.01, and 55.02)						0	56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						0	57.00
58.00 Bonus payment (see instructions)						0	58.00
59.00 Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)						0.00	59.00
60.00 Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)						0.00	60.00
61.00 Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)						0	61.00
62.00 Relief payment (see instructions)						0	62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)						0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)						0	64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						0	65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions						0	66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						0	67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						0	68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)							70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00 Program routine service cost (line 9 x line 71)							72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)							75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00 Program capital-related costs (line 9 x line 76)							77.00
78.00 Inpatient routine service cost (line 74 minus line 77)							78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00 Inpatient routine service cost per diem limitation							81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00 Reasonable inpatient routine service costs (see instructions)							83.00
84.00 Program inpatient ancillary services (see instructions)							84.00
85.00 Utilization review - physician compensation (see instructions)							85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)							86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00 Total observation bed days (see instructions)						0	87.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0042 Component CCN: 15-T042		Period: From 01/01/2022 To 12/31/2022		Worksheet D-1 Date/Time Prepared: 5/24/2023 12:05 pm	
		Title XIX		Subprovider - IRF		Cost	
Cost Center Description							
1.00							
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					0	89.00
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	731,837	5,409,538	0.135286	0	0	90.00
91.00	Nursing Program cost	0	5,409,538	0.000000	0	0	91.00
92.00	Allied health cost	0	5,409,538	0.000000	0	0	92.00
93.00	All other Medical Education	0	5,409,538	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0042	Period: From 01/01/2022 To 12/31/2022	Worksheet D-3 Date/Time Prepared: 5/24/2023 12:05 pm	
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		8,436,256	30.00
31.00	03100	INTENSIVE CARE UNIT		6,142,034	31.00
40.00	04000	SUBPROVIDER - IPF		0	40.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.188428	4,819,245	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	51.00
51.01	05101	ENDOSCOPY	0.236283	444,477	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.346482	0	52.00
53.00	05300	ANESTHESIOLOGY	0.196521	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.110236	7,116,456	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.217244	116,769	55.00
60.00	06000	LABORATORY	0.141685	9,702,273	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.296217	3,015,640	65.00
66.00	06600	PHYSICAL THERAPY	0.358015	2,956,469	66.00
69.00	06900	ELECTROCARDIOLOGY	0.164960	5,987,140	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	70.00
70.01	07001	NEURODIAGNOSTICS	0.335060	23,440	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.374545	741,746	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.466911	1,084,066	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.326122	6,534,067	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.181608	0	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0.000000	0	76.00
76.01	03951	INPATIENT DIALYSIS	0.925538	348,408	76.01
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	77.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	2.999231	0	90.00
90.01	04950	WOUND CLINIC	0.331047	5,102	90.01
91.00	09100	EMERGENCY	0.195264	5,347,351	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.497946	1,523,987	92.00
OTHER REIMBURSABLE COST CENTERS					
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.625858	0	96.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		49,766,636	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)		49,766,636	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0042 Component CCN: 15-S042	Period: From 01/01/2022 To 12/31/2022	Worksheet D-3 Date/Time Prepared: 5/24/2023 12:05 pm
		Title XVIII	Subprovider - IPF	PPS
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
		1.00	2.00	3.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
40.00	04000 SUBPROVIDER - IPF		1,049,784	40.00
41.00	04100 SUBPROVIDER - IRF			41.00
43.00	04300 NURSERY			43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.188428	19,636	50.00
51.00	05100 RECOVERY ROOM	0.000000	0	51.00
51.01	05101 ENDOSCOPY	0.236283	0	51.01
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.346482	0	52.00
53.00	05300 ANESTHESIOLOGY	0.196521	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.110236	41,812	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.217244	827	55.00
60.00	06000 LABORATORY	0.141685	167,800	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.000000	0	63.00
65.00	06500 RESPIRATORY THERAPY	0.296217	70,395	65.00
66.00	06600 PHYSICAL THERAPY	0.358015	14,518	66.00
69.00	06900 ELECTROCARDIOLOGY	0.164960	13,356	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	70.00
70.01	07001 NEURODIAGNOSTICS	0.335060	6,804	70.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1.374545	1,422	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.466911	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.326122	100,909	73.00
75.00	07500 ASC (NON-DISTINCT PART)	0.181608	0	75.00
76.00	03950 MH ANCILLARY OUTPATIENT	0.000000	0	76.00
76.01	03951 INPATIENT DIALYSIS	0.925538	0	76.01
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0.000000	0	77.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	2.999231	0	90.00
90.01	04950 WOUND CLINIC	0.331047	0	90.01
91.00	09100 EMERGENCY	0.195264	185,041	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.497946	0	92.00
OTHER REIMBURSABLE COST CENTERS				
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0.625858	0	96.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		622,520	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)		622,520	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0042 Component CCN: 15-T042	Period: From 01/01/2022 To 12/31/2022	Worksheet D-3 Date/Time Prepared: 5/24/2023 12:05 pm
		Title XVIII	Subprovider - IRF	PPS
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
		1.00	2.00	3.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
40.00	04000 SUBPROVIDER - I/PF			40.00
41.00	04100 SUBPROVIDER - IRF			41.00
43.00	04300 NURSERY		5,407,213	43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.188428	53,957	50.00
51.00	05100 RECOVERY ROOM	0.000000	0	51.00
51.01	05101 ENDOSCOPY	0.236283	13,236	51.01
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.346482	0	52.00
53.00	05300 ANESTHESIOLOGY	0.196521	502	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.110236	433,221	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.217244	0	55.00
60.00	06000 LABORATORY	0.141685	961,935	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.000000	0	63.00
65.00	06500 RESPIRATORY THERAPY	0.296217	1,153,723	65.00
66.00	06600 PHYSICAL THERAPY	0.358015	6,660,215	66.00
69.00	06900 ELECTROCARDIOLOGY	0.164960	80,351	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	70.00
70.01	07001 NEURODIAGNOSTICS	0.335060	10,830	70.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1.374545	147,289	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.466911	14,336	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.326122	1,066,667	73.00
75.00	07500 ASC (NON-DISTINCT PART)	0.181608	0	75.00
76.00	03950 MH ANCILLARY OUTPATIENT	0.000000	0	76.00
76.01	03951 INPATIENT DIALYSIS	0.925538	77,919	76.01
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0.000000	0	77.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	2.999231	308	90.00
90.01	04950 WOUND CLINIC	0.331047	0	90.01
91.00	09100 EMERGENCY	0.195264	41,678	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.497946	0	92.00
OTHER REIMBURSABLE COST CENTERS				
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0.625858	0	96.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		10,716,167	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)		10,716,167	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0042	Period: From 01/01/2022 To 12/31/2022	Worksheet D-3 Date/Time Prepared: 5/24/2023 12:05 pm	
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		183,666	30.00
31.00	03100	INTENSIVE CARE UNIT		128,890	31.00
40.00	04000	SUBPROVIDER - IPF		0	40.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
43.00	04300	NURSERY		49,229	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.188161	131,120	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	51.00
51.01	05101	ENDOSCOPY	0.236283	6,992	51.01
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.346482	217,933	52.00
53.00	05300	ANESTHESIOLOGY	0.196521	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.110236	156,640	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.217066	2,842	55.00
60.00	06000	LABORATORY	0.141685	280,195	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.296217	81,592	65.00
66.00	06600	PHYSICAL THERAPY	0.358015	49,222	66.00
69.00	06900	ELECTROCARDIOLOGY	0.164873	87,663	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	70.00
70.01	07001	NEURODIAGNOSTICS	0.332806	2,603	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.374545	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.466911	184,313	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.326122	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.181210	661	75.00
76.00	03950	MH ANCILLARY OUTPATIENT	0.000000	0	76.00
76.01	03951	INPATIENT DIALYSIS	0.925538	1,522	76.01
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	77.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	2.999231	0	90.00
90.01	04950	WOUND CLINIC	0.331047	396	90.01
91.00	09100	EMERGENCY	0.195083	166,446	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.497946	2,508	92.00
OTHER REIMBURSABLE COST CENTERS					
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.625858	0	96.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,372,648	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)		1,372,648	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0042 Component CCN: 15-S042	Period: From 01/01/2022 To 12/31/2022	Worksheet D-3 Date/Time Prepared: 5/24/2023 12:05 pm
		Title XIX	Subprovider - IPF	Cost
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
		1.00	2.00	3.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
40.00	04000 SUBPROVIDER - IPF		685,879	40.00
41.00	04100 SUBPROVIDER - IRF			41.00
43.00	04300 NURSERY			43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.188161	0	50.00
51.00	05100 RECOVERY ROOM	0.000000	0	51.00
51.01	05101 ENDOSCOPY	0.236283	0	51.01
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.346482	0	52.00
53.00	05300 ANESTHESIOLOGY	0.196521	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.110236	20,129	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.217066	0	55.00
60.00	06000 LABORATORY	0.141685	45,325	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.000000	0	63.00
65.00	06500 RESPIRATORY THERAPY	0.296217	12,682	65.00
66.00	06600 PHYSICAL THERAPY	0.358015	11,101	66.00
69.00	06900 ELECTROCARDIOLOGY	0.164873	3,348	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	70.00
70.01	07001 NEURODIAGNOSTICS	0.332806	980	70.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1.374545	2,323	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.466911	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.326122	51,126	73.00
75.00	07500 ASC (NON-DISTINCT PART)	0.181210	0	75.00
76.00	03950 MH ANCILLARY OUTPATIENT	0.000000	0	76.00
76.01	03951 INPATIENT DIALYSIS	0.925538	899	76.01
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0.000000	0	77.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	2.999231	0	90.00
90.01	04950 WOUND CLINIC	0.331047	0	90.01
91.00	09100 EMERGENCY	0.195083	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.497946	0	92.00
OTHER REIMBURSABLE COST CENTERS				
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0.625858	0	96.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		147,913	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)		147,913	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0042 Component CCN: 15-T042	Period: From 01/01/2022 To 12/31/2022	Worksheet D-3 Date/Time Prepared: 5/24/2023 12:05 pm
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
		1.00	2.00	3.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
40.00	04000 SUBPROVIDER - I/PF			40.00
41.00	04100 SUBPROVIDER - I/RF			41.00
43.00	04300 NURSERY		3,498	43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.188161	11	2 50.00
51.00	05100 RECOVERY ROOM	0.000000	0	0 51.00
51.01	05101 ENDOSCOPY	0.236283	28	7 51.01
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.346482	0	0 52.00
53.00	05300 ANESTHESIOLOGY	0.196521	0	0 53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.110236	273	30 54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.217066	0	0 55.00
60.00	06000 LABORATORY	0.141685	404	57 60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0 63.00
65.00	06500 RESPIRATORY THERAPY	0.296217	124	37 65.00
66.00	06600 PHYSICAL THERAPY	0.358015	2,872	1,028 66.00
69.00	06900 ELECTROCARDIOLOGY	0.164873	52	9 69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0 70.00
70.01	07001 NEURODIAGNOSTICS	0.332806	7	2 70.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1.374545	104	143 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.466911	4	2 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.326122	415	135 73.00
75.00	07500 ASC (NON-DISTINCT PART)	0.181210	0	0 75.00
76.00	03950 MH ANCILLARY OUTPATIENT	0.000000	0	0 76.00
76.01	03951 INPATIENT DIALYSIS	0.925538	0	0 76.01
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0.000000	0	0 77.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	2.999231	0	0 90.00
90.01	04950 WOUND CLINIC	0.331047	45	15 90.01
91.00	09100 EMERGENCY	0.195083	0	0 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.497946	0	0 92.00
OTHER REIMBURSABLE COST CENTERS				
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0.625858	0	0 96.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		4,339	1,467 200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0 201.00
202.00	Net charges (line 200 minus line 201)		4,339	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0042	Period: From 01/01/2022 To 12/31/2022	Worksheet E Part A Date/Time Prepared: 5/24/2023 12:05 pm
		Title XVIII	Hospital	PPS
		1.00		
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
1.00	DRG Amounts Other than Outlier Payments		0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		10,573,351	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		4,062,047	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)		136,221	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)		0	2.04
3.00	Managed Care Simulated Payments		5,796,239	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		90.26	4.00
Indirect Medical Education Adjustment				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions)		0.00	5.00
5.01	FTE cap adjustment for qualifying hospitals under §131 of the CAA 2021 (see instructions)		0.00	5.01
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00	6.00
6.26	Rural track program FTE cap limitation adjustment after the cap-building window closed under §127 of the CAA 2021 (see instructions)		0.00	6.26
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00	7.01
7.02	Adjustment (increase or decrease) to the hospital's rural track program FTE limitation(s) for rural track programs with a rural track for Medicare GME affiliated programs in accordance with 413.75(b) and 87 FR 49075 (August 10, 2022) (see instructions)		0.00	7.02
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		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)		32.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00	17.00
18.00	Adjusted rolling average FTE count		32.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.354531	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.359672	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.354531	21.00
22.00	IME payment adjustment (see instructions)		2,583,748	22.00
22.01	IME payment adjustment - Managed Care (see instructions)		1,023,274	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)		2,583,748	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		1,023,274	29.01
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		4.54	30.00
31.00	Percentage of Medicaid patient days (see instructions)		18.48	31.00
32.00	Sum of lines 30 and 31		23.02	32.00
33.00	Allowable disproportionate share percentage (see instructions)		8.21	33.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0042	Period: From 01/01/2022 To 12/31/2022	Worksheet E Part A Date/Time Prepared: 5/24/2023 12:05 pm	
		Title XVIII	Hospital	PPS	
				1.00	
34.00	Disproportionate share adjustment (see instructions)			300,392	34.00
			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)		0.000242542	0.000234492	35.01
35.02	Hospital UCP, including supplemental UCP (If line 34 is zero, enter zero on this line) (see instructions)		1,744,367	1,611,993	35.02
35.03	Pro rata share of the hospital UCP, including supplemental UCP (see instructions)		1,304,691	406,311	35.03
36.00	Total UCP adjustment (sum of columns 1 and 2 on line 35.03)		1,711,002		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)		19,366,761		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)		18,369,322		48.00
				Amount	
				1.00	
49.00	Total payment for inpatient operating costs (see instructions)			20,390,035	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)			1,365,760	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).			1,383,482	52.00
53.00	Nursing and Allied Health Managed Care payment			75,495	53.00
54.00	Special add-on payments for new technologies			15,311	54.00
54.01	Islet isolation add-on payment			0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)			0	55.00
55.01	Cellular therapy acquisition cost (see instructions)			0	55.01
56.00	Cost of physicians' services in a teaching hospital (see instructions)			0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).			0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)			33,987	58.00
59.00	Total (sum of amounts on lines 49 through 58)			23,264,070	59.00
60.00	Primary payer payments			0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)			23,264,070	61.00
62.00	Deductibles billed to program beneficiaries			1,901,404	62.00
63.00	Coinurance billed to program beneficiaries			39,678	63.00
64.00	Allowable bad debts (see instructions)			339,708	64.00
65.00	Adjusted reimbursable bad debts (see instructions)			220,810	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			207,938	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			21,543,798	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)			0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)			0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	70.00
70.50	Rural Community Hospital Demonstration Project (\$410A Demonstration) adjustment (see instructions)			0	70.50
70.75	N95 respirator payment adjustment amount (see instructions)			0	70.75
70.87	Demonstration payment adjustment amount before sequestration			0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)			0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)			0	70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)			0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)			0	70.91
70.92	Bundled Model 1 discount amount (see instructions)			0	70.92
70.93	HVBP payment adjustment amount (see instructions)			0	70.93
70.94	HRR adjustment amount (see instructions)			-94,016	70.94
70.95	Recovery of accelerated depreciation			0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0042	Period: From 01/01/2022 To 12/31/2022	Worksheet E Part A Date/Time Prepared: 5/24/2023 12:05 pm	
		Title XVIII	Hospital	PPS	
		FFY (yyyy)	Amount		
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	1.00	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0		0	70.97
70.98	Low Volume Payment-3			0	70.98
70.99	HAC adjustment amount (see instructions)			157,868	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)			21,291,914	71.00
71.01	Sequestration adjustment (see instructions)			268,278	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			18,918,899	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)			2,104,737	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			297,972	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)				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	100.00
HVBP Adjustment for HSP Bonus Payment					
101.00	HVBP adjustment factor (see instructions)		1.0000000000	1.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)			0	102.00
HRR Adjustment for HSP Bonus Payment					
103.00	HRR adjustment factor (see instructions)		0.9930	0.9951	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)			0	104.00
Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment					
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.				200.00
Cost Reimbursement					
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. 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
Comparison of PPS versus Cost Reimbursement					
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)				212.00
213.00	Low-volume adjustment (see instructions)				213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)				218.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 15-0042

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

Worksheet E
Part A Exhibit 4
Date/Time Prepared:
5/24/2023 12:05 pm

		Title XVIII			Hospital		PPS	
	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	1.00	
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	10,573,351	0	10,573,351		1.01	
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	4,062,047	0		4,062,047	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	136,221	0	136,221		2.02	
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	0	0		0	2.03	
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00	
4.00	Managed care simulated payments	3.00	5,796,239	0	4,284,047	1,512,192	4.00	
Indirect Medical Education Adjustment								
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.354531	0.354531	0.354531	0.354531	5.00	
6.00	IME payment adjustment (see instructions)	22.00	2,583,748	0	1,866,630	717,118	6.00	
6.01	IME payment adjustment for managed care (see instructions)	22.01	1,023,274	0	756,310	266,964	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	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	2,583,748	0	1,866,630	717,118	9.00	
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	1,023,274	0	756,310	266,964	9.01	
Disproportionate Share Adjustment								
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0821	0.0821	0.0821	0.0821	10.00	
11.00	Disproportionate share adjustment (see instructions)	34.00	300,392	0	217,018	83,374	11.00	
11.01	Uncompensated care payments	36.00	1,711,002	0	1,304,691	406,311	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	19,366,761	0	14,097,911	5,268,850	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	20,390,035	0	14,854,221	5,535,814	15.00	

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 15-0042

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

Worksheet E
Part A Exhibit 4
Date/Time Prepared:
5/24/2023 12:05 pm

		Title XVIII			Hospital		PPS	
		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	
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	1,365,760	0	995,643	370,117	1,365,760	16.00
17.00	Special add-on payments for new technologies	54.00	15,311	0	11,006	4,304	15,310	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	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	15,860,870	5,910,235	21,771,105	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	1,090,064	0	789,156	300,908	1,090,064	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	24,981	0	24,981	0	24,981	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	0.2300	0.2300	0.2300	0.2300		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	250,715	0	181,506	69,209	250,715	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	1,365,760	0	995,643	370,117	1,365,760	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				0.000000	0.000000		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			0		0	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				0	0	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: 15-0042		Period: From 01/01/2022 To 12/31/2022		Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/24/2023 12:05 pm	
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		Title XVIII		Hospital		PPS	
		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	10,573,351	10,573,351		10,573,351	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	4,062,047		4,062,047	4,062,047	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	136,221	136,221		136,221	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	0		0	0	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	5,796,239	4,284,047	1,512,192	5,796,239	4.00
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.354531	0.354531	0.354531		5.00
6.00	IME payment adjustment (see instructions)	22.00	2,583,748	1,866,630	717,118	2,583,748	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	1,023,274	756,310	266,964	1,023,274	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	2,583,748	1,866,630	717,118	2,583,748	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	1,023,274	756,310	266,964	1,023,274	9.01
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0821	0.0821	0.0821		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	300,392	217,018	83,374	300,392	11.00
11.01	Uncompensated care payments	36.00	1,711,002	1,304,691	406,311	1,711,002	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	19,366,761	14,097,911	5,268,850	19,366,761	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	20,390,035	14,854,221	5,535,814	20,390,035	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	1,365,760	995,643	370,117	1,365,760	16.00
17.00	Special add-on payments for new technologies	54.00	15,311	11,007	4,304	15,311	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			15,860,871	5,910,235	21,771,106	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5		Provider CCN: 15-0042	Period: From 01/01/2022 To 12/31/2022	Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/24/2023 12:05 pm
Title XVIII			Hospital	PPS

		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	1,090,064	789,156	300,908	1,090,064	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	24,981	24,981	0	24,981	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	0.2300	0.2300	0.2300		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	250,715	181,506	69,209	250,715	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	1,365,760	995,643	370,117	1,365,760	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	0	0		0	28.00
29.00	Low volume adjustment on or after October 1	70.97	0		0	0	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	-94,016	-74,091	-19,925	-94,016	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		157,868	0	157,868	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Y				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0042	Period: From 01/01/2022 To 12/31/2022	Worksheet E Part B Date/Time Prepared: 5/24/2023 12:05 pm
		Title XVIII	Hospital	PPS
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		8,315	1.00
2.00	Medical and other services reimbursed under OPPTS (see instructions)		29,353,479	2.00
3.00	OPPTS payments		25,894,964	3.00
4.00	Outlier payment (see instructions)		14,362	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		24,191	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		8,315	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		25,531	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)		25,531	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		25,531	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		17,216	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)		8,315	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)		25,933,517	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		4,801,063	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)		21,140,769	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		1,268,238	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)		22,409,007	30.00
31.00	Primary payer payments		2,324	31.00
32.00	Subtotal (line 30 minus line 31)		22,406,683	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)		738,769	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		480,200	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		533,599	36.00
37.00	Subtotal (see instructions)		22,886,883	37.00
38.00	MSP-LCC reconciliation amount from PS&R		-1	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)		22,886,884	40.00
40.01	Sequestration adjustment (see instructions)		288,375	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		22,098,168	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)		500,341	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)			93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0042	Period: From 01/01/2022 To 12/31/2022	Worksheet E Part B Date/Time Prepared: 5/24/2023 12:05 pm
	Title XVIII	Hospital	PPS
			1.00
200.00 MEDICARE PART B ANCILLARY COSTS Part B Combined Billed Days			0 200.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0042 Component CCN: 15-S042	Period: From 01/01/2022 To 12/31/2022	Worksheet E Part B Date/Time Prepared: 5/24/2023 12:05 pm
		Title XVIII	Subprovider - IPF	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		34	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		150	2.00
3.00	OPPS payments		207	3.00
4.00	Outlier payment (see instructions)		0	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		34	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		105	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)		105	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		105	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		71	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)		34	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)		207	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		12	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)		229	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)		229	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		229	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Wkst. 1-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		1,536	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		998	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		1,536	36.00
37.00	Subtotal (see instructions)		1,227	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.75	N95 respirator payment adjustment amount (see instructions)		0	39.75
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		1,227	40.00
40.01	Sequestration adjustment (see instructions)		15	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
40.03	Sequestration adjustment-PARHM or CHART pass-throughs		0	40.03
41.00	Interim payments		224	41.00
41.01	Interim payments-PARHM or CHART		0	41.01
42.00	Tentative settlement (for contractors use only)		0	42.00
42.01	Tentative settlement-PARHM or CHART (for contractor use only)		0	42.01
43.00	Balance due provider/program (see instructions)		988	43.00
43.01	Balance due provider/program-PARHM (see instructions)		0	43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0042 Component CCN: 15-S042	Period: From 01/01/2022 To 12/31/2022	Worksheet E Part B Date/Time Prepared: 5/24/2023 12:05 pm
	Title XVIII	Subprovider - IPF	PPS
			1.00
200.00	MEDI CARE PART B ANCILLARY COSTS Part B Combined Billed Days		
			200.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0042 Component CCN: 15-T042	Period: From 01/01/2022 To 12/31/2022	Worksheet E Part B Date/Time Prepared: 5/24/2023 12:05 pm
		Title XVIII	Subprovider - IRF	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		245	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		3,460	2.00
3.00	OPPS payments		1,306	3.00
4.00	Outlier payment (see instructions)		0	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		5	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		245	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		751	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)		751	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		751	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		506	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)		245	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)		1,311	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		194	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)		1,362	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)		1,362	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		1,362	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Wkst. 1-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00
37.00	Subtotal (see instructions)		1,362	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	39.50
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)		1,362	40.00
40.01	Sequestration adjustment (see instructions)		17	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
40.03	Sequestration adjustment-PARHM or CHART pass-throughs		0	40.03
41.00	Interim payments		1,310	41.00
41.01	Interim payments-PARHM or CHART		0	41.01
42.00	Tentative settlement (for contractors use only)		0	42.00
42.01	Tentative settlement-PARHM or CHART (for contractor use only)		0	42.01
43.00	Balance due provider/program (see instructions)		35	43.00
43.01	Balance due provider/program-PARHM (see instructions)		0	43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0042 Component CCN: 15-T042	Period: From 01/01/2022 To 12/31/2022	Worksheet E Part B Date/Time Prepared: 5/24/2023 12:05 pm
	Title XVIII	Subprovider - IRF	PPS
	1.00		
200.00 MEDICARE PART B ANCILLARY COSTS			200.00
Part B Combined Billed Days			

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-0042

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

Worksheet E-1
Part I
Date/Time Prepared:
5/24/2023 12:05 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		17,522,415		20,835,354	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	07/27/2022	173,900	07/27/2022	124,700		3.01
3.02		10/12/2022	288,400	10/12/2022	164,100		3.02
3.03		12/31/2022	934,184	12/31/2022	974,014		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)		1,396,484		1,262,814		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)		18,918,899		22,098,168		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		2,104,737		500,341		6.01
6.02	SETTLEMENT TO PROGRAM		0		0		6.02
7.00	Total Medicare program liability (see instructions)		21,023,636		22,598,509		7.00
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor						8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		Provider CCN: 15-0042 Component CCN: 15-S042	Period: From 01/01/2022 To 12/31/2022	Worksheet E-1 Part I Date/Time Prepared: 5/24/2023 12:05 pm	
		Title XVIII	Subprovider - IPF	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				224 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		547,793		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)				0 3.00
Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0 3.01
3.02			0		0 3.02
3.03			0		0 3.03
3.04			0		0 3.04
3.05			0		0 3.05
Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0 3.50
3.51			0		0 3.51
3.52			0		0 3.52
3.53			0		0 3.53
3.54			0		0 3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0 3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		547,793		224 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)				0 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)				0 6.00
6.01	SETTLEMENT TO PROVIDER		34,829		988 6.01
6.02	SETTLEMENT TO PROGRAM		0		0 6.02
7.00	Total Medicare program liability (see instructions)		582,622		1,212 7.00
				Contractor Number	NPR Date (Mo/Day/Yr)
			0	1.00	2.00
8.00	Name of Contractor				0 8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-0042
Component CCN: 15-T042

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

Worksheet E-1
Part I
Date/Time Prepared:
5/24/2023 12:05 pm
PPS

Title XVIII

Subprovider -
IRF

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider					1.00
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		7,634,899		1,310	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		7,634,899		1,310	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		35	6.01
6.02	SETTLEMENT TO PROGRAM		38,671		0	6.02
7.00	Total Medicare program liability (see instructions)		7,596,228		1,345	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: 15-0042	Period: From 01/01/2022 To 12/31/2022	Worksheet E-1 Part II Date/Time Prepared: 5/24/2023 12:05 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 IPSS & 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: 15-0042 Component CCN: 15-S042	Period: From 01/01/2022 To 12/31/2022	Worksheet E-3 Part II Date/Time Prepared: 5/24/2023 12:05 pm
		Title XVIII	Subprovider - IPF	PPS
				1.00
PART II - MEDICARE PART A SERVICES - IPF PPS				
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)			582,293 1.00
2.00	Net IPF PPS Outlier Payments			0 2.00
3.00	Net IPF PPS ECT Payments			3,880 3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)			0.00 4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			0.00 4.01
5.00	New Teaching program adjustment. (see instructions)			0.00 5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)			0.00 6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)			3.57 7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)			3.57 8.00
9.00	Average Daily Census (see instructions)			11.649315 9.00
10.00	Teaching Adjustment Factor $\{(1 + (\text{line 8}/\text{line 9})) \text{ raised to the power of } .5150 - 1\}$.			0.147595 10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).			85,944 11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)			672,117 12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)			0 13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)			0 14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)			0 15.00
16.00	Subtotal (see instructions)			672,117 16.00
17.00	Primary payer payments			0 17.00
18.00	Subtotal (line 16 less line 17).			672,117 18.00
19.00	Deductibles			91,804 19.00
20.00	Subtotal (line 18 minus line 19)			580,313 20.00
21.00	Coinsurance			8,947 21.00
22.00	Subtotal (line 20 minus line 21)			571,366 22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			27,850 23.00
24.00	Adjusted reimbursable bad debts (see instructions)			18,103 24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			19,294 25.00
26.00	Subtotal (sum of lines 22 and 24)			589,469 26.00
27.00	Direct graduate medical education payments (see instructions)			0 27.00
28.00	Other pass through costs (see instructions)			588 28.00
29.00	Outlier payments reconciliation			0 29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 30.50
30.98	Recovery of accelerated depreciation.			0 30.98
30.99	Demonstration payment adjustment amount before sequestration			0 30.99
31.00	Total amount payable to the provider (see instructions)			590,057 31.00
31.01	Sequestration adjustment (see instructions)			7,435 31.01
31.02	Demonstration payment adjustment amount after sequestration			0 31.02
32.00	Interim payments			547,793 32.00
33.00	Tentative settlement (for contractor use only)			0 33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)			34,829 34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 35.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Worksheet E-3, Part II, line 2			0 50.00
51.00	Outlier reconciliation adjustment amount (see instructions)			0 51.00
52.00	The rate used to calculate the Time Value of Money			0.00 52.00
53.00	Time Value of Money (see instructions)			0 53.00
FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING BEFORE THE END OF THE COVID-19 PHE				
99.00	Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020.			0.000000 99.00
99.01	Calculated Teaching Adjustment Factor for the current year. (see instructions)			0.147595 99.01

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0042 Component CCN: 15-T042	Period: From 01/01/2022 To 12/31/2022	Worksheet E-3 Part III Date/Time Prepared: 5/24/2023 12:05 pm
		Title XVIII	Subprovider - IRF	PPS
				1.00
PART III - MEDICARE PART A SERVICES - IRF PPS				
1.00	Net Federal PPS Payment (see instructions)			7,570,780 1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)			0.0193 2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)			134,760 3.00
4.00	Outlier Payments			118,533 4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)			0.00 5.00
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			0.00 5.01
6.00	New Teaching program adjustment. (see instructions)			0.00 6.00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)			0.00 7.00
8.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)			0.00 8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)			0.00 9.00
10.00	Average Daily Census (see instructions)			16.526027 10.00
11.00	Teaching Adjustment Factor (see instructions)			0.000000 11.00
12.00	Teaching Adjustment (see instructions)			0 12.00
13.00	Total PPS Payment (see instructions)			7,824,073 13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)			0 14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)			0 15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)			0 16.00
17.00	Subtotal (see instructions)			7,824,073 17.00
18.00	Primary payer payments			14,872 18.00
19.00	Subtotal (line 17 less line 18).			7,809,201 19.00
20.00	Deductibles			77,512 20.00
21.00	Subtotal (line 19 minus line 20)			7,731,689 21.00
22.00	Coinurance			47,458 22.00
23.00	Subtotal (line 21 minus line 22)			7,684,231 23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			8,556 24.00
25.00	Adjusted reimbursable bad debts (see instructions)			5,561 25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			4,596 26.00
27.00	Subtotal (sum of lines 23 and 25)			7,689,792 27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 49)			0 28.00
29.00	Other pass through costs (see instructions)			3,370 29.00
30.00	Outlier payments reconciliation			0 30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 31.00
31.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 31.50
31.98	Recovery of accelerated depreciation.			0 31.98
31.99	Demonstration payment adjustment amount before sequestration			0 31.99
32.00	Total amount payable to the provider (see instructions)			7,693,162 32.00
32.01	Sequestration adjustment (see instructions)			96,934 32.01
32.02	Demonstration payment adjustment amount after sequestration			0 32.02
33.00	Interim payments			7,634,899 33.00
34.00	Tentative settlement (for contractor use only)			0 34.00
35.00	Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)			-38,671 35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 36.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4			118,533 50.00
51.00	Outlier reconciliation adjustment amount (see instructions)			0 51.00
52.00	The rate used to calculate the Time Value of Money			0.00 52.00
53.00	Time Value of Money (see instructions)			0 53.00
FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING BEFORE THE END OF THE COVID-19 PHE				
99.00	Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020.			0.000000 99.00
99.01	Calculated Teaching Adjustment Factor for the current year. (see instructions)			0.000000 99.01

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0042	Period: From 01/01/2022 To 12/31/2022	Worksheet E-3 Part VII Date/Time Prepared: 5/24/2023 12:05 pm	
		Title XIX	Hospital	Cost	
			Inpatient	Outpatient	
			1.00	2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES					
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient hospital/SNF/NF services		1,145,459		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)		1,145,459	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)		1,145,459	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges		361,785		8.00
9.00	Ancillary service charges		1,372,648	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)		1,734,433	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)		1,734,433	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		588,974	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)		1,145,459	0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.					
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0		25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		1,145,459	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)		1,145,459	0	31.00
32.00	Deductibles		0		32.00
33.00	Coinurance		446	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)		1,145,013	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37.00
38.00	Subtotal (line 36 ± line 37)		1,145,013	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)		1,145,013	0	40.00
41.00	Interim payments		985,490	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)		159,523	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

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0042 Component CCN: 15-S042	Period: From 01/01/2022 To 12/31/2022	Worksheet E-3 Part VII Date/Time Prepared: 5/24/2023 12:05 pm
		Title XIX	Subprovider - IPF	Cost
			Inpatient 1.00	Outpatient 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		318,996	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)		318,996	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)		318,996	7.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable Charges				
8.00	Routine service charges		685,879	8.00
9.00	Ancillary service charges		147,913	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)		833,792	12.00
CUSTOMARY CHARGES				
13.00	Amount actually collected from patients liable for payment for services on a charge basis		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	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000
16.00	Total customary charges (see instructions)		833,792	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		514,796	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		0	18.00
19.00	Interns and Residents (see instructions)		0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)		0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		318,996	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.				
22.00	Other than outlier payments		0	22.00
23.00	Outlier payments		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	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		318,996	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)		0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		318,996	31.00
32.00	Deductibles		0	32.00
33.00	Coinurance		0	33.00
34.00	Allowable bad debts (see instructions)		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)		318,996	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	37.00
38.00	Subtotal (line 36 ± line 37)		318,996	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)		318,996	40.00
41.00	Interim payments		361,349	41.00
42.00	Balance due provider/program (line 40 minus line 41)		-42,353	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2		0	43.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0042 Component CCN: 15-T042	Period: From 01/01/2022 To 12/31/2022	Worksheet E-3 Part VII Date/Time Prepared: 5/24/2023 12:05 pm
		Title XIX	Subprovider - IRF	Cost
		Inpatient 1.00	Outpatient 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	25,681		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)	25,681	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)	25,681	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable Charges				
8.00	Routine service charges	3,498		8.00
9.00	Ancillary service charges	4,339	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)	7,837	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)	7,837	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	0	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	17,844	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)	7,837	0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.				
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0	0	24.00
25.00	Capital exception payments (see instructions)	0	0	25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	7,837	0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)	17,844	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	7,837	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0	0	35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	7,837	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	7,837	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0	0	39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	7,837	0	40.00
41.00	Interim payments	6,952	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	885	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

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 15-0042		Period: From 01/01/2022 To 12/31/2022		Worksheet E-4	
		Title XVIII		Hospital		Date/Time Prepared: 5/24/2023 12:05 pm	
				PPS			
						1.00	
COMPUTATION OF TOTAL DIRECT GME AMOUNT							
1.00	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.					0.00	1.00
1.01	FTE cap adjustment under §131 of the CAA 2021 (see instructions)					0.00	1.01
2.00	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)					0.00	2.00
2.26	Rural track program FTE cap limitation adjustment after the cap-building window closed under §127 of the CAA 2021 (see instructions)						2.26
3.00	Amount of reduction to Direct GME cap under section 422 of MMA					0.00	3.00
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)					0.00	3.01
3.02	Adjustment (increase or decrease) to the hospital's rural track FTE limitation(s) for rural track programs with a rural track Medicare GME affiliation agreement in accordance with 413.75(b) and 87 FR 49075 (August 10, 2022) (see instructions)						3.02
4.00	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))					0.00	4.00
4.01	ACA Section 5503 increase to the Direct GME FTE Cap (see instructions for cost reporting periods straddling 7/1/2011)					0.00	4.01
4.02	ACA Section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)					0.00	4.02
4.21	The amount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (see instructions)						4.21
5.00	FTE adjusted cap (line 1 plus and 1.01, plus line 2, plus lines 2.26 through 2.49, minus lines 3 and 3.01, plus or minus line 3.02, plus or minus line 4, plus lines 4.01 through 4.27					0.00	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)					0.00	6.00
7.00	Enter the lesser of line 5 or line 6					0.00	7.00
		Primary Care	Other			Total	
		1.00	2.00			3.00	
8.00	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year.	0.00	0.00			0.00	8.00
9.00	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6. For cost reporting periods beginning on or after October 1, 2022, or if Worksheet S-2, Part I, line 68, is "Y", see instructions.	0.00	0.00			0.00	9.00
10.00	Weighted dental and podiatric resident FTE count for the current year		0.00				10.00
10.01	Unweighted dental and podiatric resident FTE count for the current year		0.00				10.01
11.00	Total weighted FTE count	0.00	0.00				11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	0.00	0.00				12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	0.00	0.00				13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	0.00	0.00				14.00
15.00	Adjustment for residents in initial years of new programs	21.04	14.53				15.00
15.01	Unweighted adjustment for residents in initial years of new programs	21.04	14.53				15.01
16.00	Adjustment for residents displaced by program or hospital closure	0.00	0.00				16.00
16.01	Unweighted adjustment for residents displaced by program or hospital closure	0.00	0.00				16.01
17.00	Adjusted rolling average FTE count	21.04	14.53				17.00
18.00	Per resident amount	122,501.52	122,501.52				18.00
18.01	Per resident amount under §131 of the CAA 2021						18.01
19.00	Approved amount for resident costs	2,577,432	1,779,947			4,357,379	19.00
						1.00	
20.00	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 Sec. 413.79(c)(4)					0.00	20.00
21.00	Direct GME FTE unweighted resident count over cap (see instructions)					0.00	21.00
22.00	Allowable additional direct GME FTE Resident Count (see instructions)					0.00	22.00
23.00	Enter the locality adjustment national average per resident amount (see instructions)					0.00	23.00
24.00	Multiply line 22 time line 23					0	24.00
25.00	Total direct GME amount (sum of lines 19 and 24)					4,357,379	25.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS	Provider CCN: 15-0042	Period: From 01/01/2022 To 12/31/2022	Worksheet E-4 Date/Time Prepared: 5/24/2023 12:05 pm
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		Title XVIII		Hospital	PPS
		Inpatient Part A	Managed Care	Total	
		1.00	2.00	3.00	
COMPUTATION OF PROGRAM PATIENT LOAD					
26.00	Inpatient Days (see instructions) (Title XIX - see S-2 Part IX, line 3.02, column 2)	12,421	3,647		26.00
27.00	Total Inpatient Days (see instructions)	26,208	26,208		27.00
28.00	Ratio of inpatient days to total inpatient days	0.473939	0.139156		28.00
29.00	Program direct GME amount	2,065,132	606,355	2,671,487	29.00
29.01	Percent reduction for MA DGME		3.26		29.01
30.00	Reduction for direct GME payments for Medicare Advantage		19,767	19,767	30.00
31.00	Net Program direct GME amount			2,651,720	31.00
				1.00	
DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING PROGRAM AND PARAMEDICAL EDUCATION COSTS)					
32.00	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)			0	32.00
33.00	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)			0	33.00
34.00	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)			0.000000	34.00
35.00	Medicare outpatient ESRD charges (see instructions)			0	35.00
36.00	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)			0	36.00
APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY					
Part A Reasonable Cost					
37.00	Reasonable cost (see instructions)			32,072,828	37.00
38.00	Organ acquisition and HSCT acquisition costs (see instructions)			0	38.00
39.00	Cost of physicians' services in a teaching hospital (see instructions)			0	39.00
40.00	Primary payer payments (see instructions)			14,872	40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)			32,057,956	41.00
Part B Reasonable Cost					
42.00	Reasonable cost (see instructions)			29,389,879	42.00
43.00	Primary payer payments (see instructions)			2,324	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)			29,387,555	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)			61,445,511	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)			0.521730	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)			0.478270	47.00
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B					
48.00	Total program GME payment (line 31)			2,651,720	48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)			1,383,482	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)			1,268,238	50.00

OUTLIER RECONCILIATION AT TENTATIVE SETTLEMENT		Provider CCN: 15-0042	Period: From 01/01/2022 To 12/31/2022	Worksheet E-5 Date/Time Prepared: 5/24/2023 12:05 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. 1, 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: 15-0042

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

Worksheet G

Date/Time Prepared:
5/24/2023 12:05 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	17,039,838	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	71,158,169	0	0	0	4.00
5.00	Other receivable	9,901,214	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-44,831,051	0	0	0	6.00
7.00	Inventory	2,789,444	0	0	0	7.00
8.00	Prepaid expenses	6,194,487	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)	62,252,101	0	0	0	11.00
FIXED ASSETS						
12.00	Land	6,581,448	0	0	0	12.00
13.00	Land improvements	10,726,598	0	0	0	13.00
14.00	Accumulated depreciation	-7,697,881	0	0	0	14.00
15.00	Buildings	173,358,126	0	0	0	15.00
16.00	Accumulated depreciation	-90,044,306	0	0	0	16.00
17.00	Leasehold improvements	515,426	0	0	0	17.00
18.00	Accumulated depreciation	-409,980	0	0	0	18.00
19.00	Fixed equipment	111,444,645	0	0	0	19.00
20.00	Accumulated depreciation	-70,500,937	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	118,442,544	0	0	0	23.00
24.00	Accumulated depreciation	-100,142,699	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)	152,272,984	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	91,839,733	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	-2,166,914	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	89,672,819	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	304,197,904	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	3,319,470	0	0	0	37.00
38.00	Salaries, wages, and fees payable	13,595,903	0	0	0	38.00
39.00	Payroll taxes payable	-29,617	0	0	0	39.00
40.00	Notes and loans payable (short term)	9,327,429	0	0	0	40.00
41.00	Deferred income	58,297	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	-526,122	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	25,745,360	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	101,035,764	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	-261,868	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	100,773,896	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	126,519,256	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	177,678,648				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)	177,678,648	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	304,197,904	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 15-0042

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

Worksheet G-1

Date/Time Prepared:
5/24/2023 12:05 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		193,490,604		0		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		-15,652,713				2.00
3.00	Total (sum of line 1 and line 2)		177,837,891		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		177,837,891		0		11.00
12.00	Deductions	159,243		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)		159,243		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		177,678,648		0		19.00
		Endowment Fund	Plant Fund				
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	Deductions		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: 15-0042

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

Worksheet G-2
Parts I & II
Date/Time Prepared:
5/24/2023 12:05 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	21,685,712		21,685,712	1.00
2.00	SUBPROVIDER - IPF	8,114,921		8,114,921	2.00
3.00	SUBPROVIDER - IRF	7,118,410		7,118,410	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)	36,919,043		36,919,043	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	14,778,797		14,778,797	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	14,778,797		14,778,797	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	51,697,840		51,697,840	17.00
18.00	Ancillary services	119,563,305	360,878,551	480,441,856	18.00
19.00	Outpatient services	11,605,204	51,758,100	63,363,304	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		0	0	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	0	2,810,651	2,810,651	26.00
27.00	DME	0	370,407	370,407	27.00
27.01	PHYSICIAN OFFICE	1,834,673	49,761,295	51,595,968	27.01
27.02	PROFESSIONAL FEES	4,642,772	15,529,537	20,172,309	27.02
27.03	DIETARY REVENUE	0	630,541	630,541	27.03
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	189,343,794	481,739,082	671,082,876	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		263,261,774		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)		263,261,774		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 15-0042

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

Worksheet G-3

Date/Time Prepared:
5/24/2023 12:05 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	671,082,876	1.00
2.00	Less contractual allowances and discounts on patients' accounts	437,983,747	2.00
3.00	Net patient revenues (line 1 minus line 2)	233,099,129	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	263,261,774	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-30,162,645	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	9,021,453	23.00
24.00	OTHER OPERATING INCOME	5,717,174	24.00
24.01	INTEREST INCOME & DISTRIBUTIONS	-6,925,536	24.01
24.02	OTHER INCOME	1,292,182	24.02
24.03	OTHER NONOPERATING INCOME	982,464	24.03
24.04	UNREALIZED GAIN/LOSS ON INVESTMENTS	2,222,195	24.04
24.50	COVID-19 PHE Funding	2,200,000	24.50
25.00	Total other income (sum of lines 6-24)	14,509,932	25.00
26.00	Total (line 5 plus line 25)	-15,652,713	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)	-15,652,713	29.00

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS	Provider CCN: 15-0042 Hospice CCN: 15-1526	Period: From 01/01/2022 To 12/31/2022	Worksheet 0 Date/Time Prepared: 5/24/2023 12:05 pm
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	Hospice I					
	SALARIES	OTHER	SUBTOTAL (col. 1 plus col. 2)	RECLASSIFI- CATIONS	SUBTOTAL	
	1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS						
1.00						1.00
2.00						2.00
3.00						3.00
4.00	68,892	211,967	280,859	-124,785	156,074	4.00
5.00		7,241	7,241		7,241	5.00
6.00						6.00
7.00						7.00
8.00						8.00
9.00						9.00
10.00		243,007	243,007		243,007	10.00
11.00						11.00
12.00						12.00
13.00						13.00
14.00		6,108	6,108		6,108	14.00
15.00						15.00
16.00						16.00
17.00						17.00
DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00						25.00
26.00	18,839	21,889	40,728		40,728	26.00
27.00	2,687		2,687		2,687	27.00
28.00	294,256		294,256		294,256	28.00
29.00						29.00
30.00						30.00
31.00						31.00
32.00						32.00
33.00	95,507		95,507		95,507	33.00
34.00						34.00
35.00						35.00
36.00						36.00
37.00	33,487		33,487		33,487	37.00
38.00						38.00
39.00						39.00
40.00						40.00
41.00						41.00
42.00						42.00
42.50						42.50
43.00						43.00
44.00						44.00
45.00						45.00
46.00						46.00
NONREIMBURSABLE COST CENTERS						
60.00						60.00
61.00						61.00
62.00						62.00
63.00						63.00
64.00						64.00
65.00						65.00
66.00						66.00
67.00						67.00
68.00						68.00
69.00						69.00
70.00						70.00
71.00						71.00
100.00	513,668	614,997	1,128,665	-124,785	1,003,880	100.00

* Transfer the amounts in column 7 to Wkst. 0-5, column 1, line as appropriate.

** See instructions. Do not transfer the amounts in column 7 to Wkst. 0-5.

ANALYSIS OF HOSPITAL-BASED HOSPI CE COSTS

Provider CCN: 15-0042

Period: From 01/01/2022

Worksheet 0

Hospice CCN: 15-1526

To 12/31/2022

Date/Time Prepared: 5/24/2023 12:05 pm

		ADJUSTMENTS	TOTAL (col . 5 ± col . 6)	Hospice I
		6.00	7.00	
GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT*	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP*	0	0	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	124,785	3.00
4.00	ADMINISTRATIVE & GENERAL*	0	156,074	4.00
5.00	PLANT OPERATION & MAINTENANCE*	0	7,241	5.00
6.00	LAUNDRY & LINEN SERVICE*	0	0	6.00
7.00	HOUSEKEEPING*	0	0	7.00
8.00	DIETARY*	0	0	8.00
9.00	NURSING ADMINISTRATION*	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES*	0	243,007	10.00
11.00	MEDICAL RECORDS*	0	0	11.00
12.00	STAFF TRANSPORTATION*	0	0	12.00
13.00	VOLUNTEER SERVICE COORDINATION*	0	0	13.00
14.00	PHARMACY*	0	6,108	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0	15.00
16.00	OTHER GENERAL SERVICE*	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0	17.00
DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED**	0	0	25.00
26.00	PHYSICIAN SERVICES**	0	40,728	26.00
27.00	NURSE PRACTITIONER**	0	2,687	27.00
28.00	REGISTERED NURSE**	0	294,256	28.00
29.00	LPN/LVN**	0	0	29.00
30.00	PHYSICAL THERAPY**	0	0	30.00
31.00	OCCUPATIONAL THERAPY**	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES**	0	95,507	33.00
34.00	SPIRITUAL COUNSELING**	0	0	34.00
35.00	DIETARY COUNSELING**	0	0	35.00
36.00	COUNSELING - OTHER**	0	0	36.00
37.00	HOSPI CE AIDE & HOME MAKER SERVICES**	0	33,487	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	0	38.00
39.00	PATIENT TRANSPORTATION**	0	0	39.00
40.00	IMAGING SERVICES**	0	0	40.00
41.00	LABS & DIAGNOSTICS**	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE**	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS**	0	0	42.50
43.00	OUTPATIENT SERVICES**	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY**	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY**	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	0	46.00
NONREIMBURSABLE COST CENTERS				
60.00	BEREAVEMENT PROGRAM *	0	0	60.00
61.00	VOLUNTEER PROGRAM *	0	0	61.00
62.00	FUNDRAISING*	0	0	62.00
63.00	HOSPI CE/PALLIATIVE MEDICINE FELLOWS*	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM*	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES*	0	0	65.00
66.00	RESIDENTIAL CARE*	0	0	66.00
67.00	ADVERTISING*	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING*	0	0	68.00
69.00	THRIFT STORE*	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD*	0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)*	0	0	71.00
100.00	TOTAL	0	1,003,880	100.00

* Transfer the amounts in column 7 to Wkst. 0-5, column 1, line as appropriate.

** See instructions. Do not transfer the amounts in column 7 to Wkst. 0-5.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPICE ROUTINE HOME CARE	Provider CCN: 15-0042 Hospice CCN: 15-1526	Period: From 01/01/2022 To 12/31/2022	Worksheet 0-2 Date/Time Prepared: 5/24/2023 12:05 pm
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	SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	Hospice I RECLASSIFI- CATIONS	SUBTOTAL	
	1.00	2.00	3.00	4.00	5.00	
DI RECT PATIENT CARE SERVICE COST CENTERS						
25.00						25.00
26.00	17,643	0	17,643	0	17,643	26.00
27.00	2,516	0	2,516	0	2,516	27.00
28.00	275,571	0	275,571	0	275,571	28.00
29.00	0	0	0	0	0	29.00
30.00	0	0	0	0	0	30.00
31.00	0	0	0	0	0	31.00
32.00	0	0	0	0	0	32.00
33.00	89,442	0	89,442	0	89,442	33.00
34.00	0	0	0	0	0	34.00
35.00	0	0	0	0	0	35.00
36.00	0	0	0	0	0	36.00
37.00	31,360	0	31,360	0	31,360	37.00
38.00	0	0	0	0	0	38.00
39.00	0	0	0	0	0	39.00
40.00	0	0	0	0	0	40.00
41.00	0	0	0	0	0	41.00
42.00	0	0	0	0	0	42.00
42.50	0	0	0	0	0	42.50
43.00	0	0	0	0	0	43.00
44.00	0	0	0	0	0	44.00
45.00	0	0	0	0	0	45.00
46.00	0	0	0	0	0	46.00
100.00	416,532	0	416,532	0	416,532	100.00

* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 51.

	ADJUSTMENTS	TOTAL (col. 5 ± col. 6)	
	6.00	7.00	
DI RECT PATIENT CARE SERVICE COST CENTERS			
25.00			25.00
26.00	0	17,643	26.00
27.00	0	2,516	27.00
28.00	0	275,571	28.00
29.00	0	0	29.00
30.00	0	0	30.00
31.00	0	0	31.00
32.00	0	0	32.00
33.00	0	89,442	33.00
34.00	0	0	34.00
35.00	0	0	35.00
36.00	0	0	36.00
37.00	0	31,360	37.00
38.00	0	0	38.00
39.00	0	0	39.00
40.00	0	0	40.00
41.00	0	0	41.00
42.00	0	0	42.00
42.50	0	0	42.50
43.00	0	0	43.00
44.00	0	0	44.00
45.00	0	0	45.00
46.00	0	0	46.00
100.00	0	416,532	100.00

* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 51.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPICE INPATIENT RESPIRE CARE

Provider CCN: 15-0042

Period: From 01/01/2022

Worksheet 0-3

Hospice CCN: 15-1526

To 12/31/2022

Date/Time Prepared: 5/24/2023 12:05 pm

	Hospice I					
	SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI- CATIONS	SUBTOTAL	
	1.00	2.00	3.00	4.00	5.00	
DI RECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED		0	0	0	25.00
26.00	PHYSICIAN SERVICES	315	0	315	0	26.00
27.00	NURSE PRACTITIONER	45	0	45	0	27.00
28.00	REGISTERED NURSE	4,919	0	4,919	0	28.00
29.00	LPN/LVN	0	0	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	1,597	0	1,597	0	33.00
34.00	SPIRITUAL COUNSELING	0	0	0	0	34.00
35.00	DIETARY COUNSELING	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOME MAKER SERVICES	560	0	560	0	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	0	0	39.00
40.00	IMAGING SERVICES	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	46.00
100.00	TOTAL *	7,436	0	7,436	0	100.00

* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 52.

	ADJUSTMENTS	TOTAL (col. 5 ± col. 6)	
	6.00	7.00	
DI RECT PATIENT CARE SERVICE COST CENTERS			
25.00	INPATIENT CARE-CONTRACTED	0	25.00
26.00	PHYSICIAN SERVICES	315	26.00
27.00	NURSE PRACTITIONER	45	27.00
28.00	REGISTERED NURSE	4,919	28.00
29.00	LPN/LVN	0	29.00
30.00	PHYSICAL THERAPY	0	30.00
31.00	OCCUPATIONAL THERAPY	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	32.00
33.00	MEDICAL SOCIAL SERVICES	1,597	33.00
34.00	SPIRITUAL COUNSELING	0	34.00
35.00	DIETARY COUNSELING	0	35.00
36.00	COUNSELING - OTHER	0	36.00
37.00	HOSPICE AIDE & HOME MAKER SERVICES	560	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	38.00
39.00	PATIENT TRANSPORTATION	0	39.00
40.00	IMAGING SERVICES	0	40.00
41.00	LABS & DIAGNOSTICS	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	42.50
43.00	OUTPATIENT SERVICES	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	46.00
100.00	TOTAL *	7,436	100.00

* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 52.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPICE GENERAL INPATIENT CARE	Provider CCN: 15-0042 Hospice CCN: 15-1526	Period: From 01/01/2022 To 12/31/2022	Worksheet 0-4 Date/Time Prepared: 5/24/2023 12:05 pm
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	Hospice I					
	SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI- CATIONS	SUBTOTAL	
	1.00	2.00	3.00	4.00	5.00	
DI RECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED	0	0	0	0	25.00
26.00	PHYSICIAN SERVICES	881	21,889	22,770	0	26.00
27.00	NURSE PRACTITIONER	126	0	126	0	27.00
28.00	REGISTERED NURSE	13,766	0	13,766	0	28.00
29.00	LPN/LVN	0	0	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	4,468	0	4,468	0	33.00
34.00	SPIRITUAL COUNSELING	0	0	0	0	34.00
35.00	DIETARY COUNSELING	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOME MAKER SERVICES	1,567	0	1,567	0	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	0	0	39.00
40.00	IMAGING SERVICES	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	46.00
100.00	TOTAL *	20,808	21,889	42,697	0	100.00

* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 53.

	ADJUSTMENTS	TOTAL (col. 5 ± col. 6)	
	6.00	7.00	
DI RECT PATIENT CARE SERVICE COST CENTERS			
25.00	INPATIENT CARE-CONTRACTED	0	25.00
26.00	PHYSICIAN SERVICES	22,770	26.00
27.00	NURSE PRACTITIONER	126	27.00
28.00	REGISTERED NURSE	13,766	28.00
29.00	LPN/LVN	0	29.00
30.00	PHYSICAL THERAPY	0	30.00
31.00	OCCUPATIONAL THERAPY	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	32.00
33.00	MEDICAL SOCIAL SERVICES	4,468	33.00
34.00	SPIRITUAL COUNSELING	0	34.00
35.00	DIETARY COUNSELING	0	35.00
36.00	COUNSELING - OTHER	0	36.00
37.00	HOSPICE AIDE & HOME MAKER SERVICES	1,567	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	38.00
39.00	PATIENT TRANSPORTATION	0	39.00
40.00	IMAGING SERVICES	0	40.00
41.00	LABS & DIAGNOSTICS	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	42.50
43.00	OUTPATIENT SERVICES	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	46.00
100.00	TOTAL *	42,697	100.00

* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 53.

COST ALLOCATION - DETERMINATION OF HOSPITAL-BASED HOSPICE NET EXPENSES FOR ALLOCATION

Provider CCN: 15-0042
 Hospice CCN: 15-1526

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

Worksheet 0-5
 Date/Time Prepared:
 5/24/2023 12:05 pm

Descriptions	Hospice I		TOTAL EXPENSES (sum of col s. 1 + 2)	
	HOSPICE DIRECT EXPENSES (see instructions)	GENERAL SERVICE EXPENSES FROM WKST B PART I (see instructions)		
	1.00	2.00	3.00	
GENERAL SERVICE COST CENTERS				
1.00 CAP REL COSTS-BLDG & FIXT	0	114,958	114,958	1.00
2.00 CAP REL COSTS-MVBLE EQUIP	0	2,530	2,530	2.00
3.00 EMPLOYEE BENEFITS DEPARTMENT	124,785	163,788	288,573	3.00
4.00 ADMINISTRATIVE & GENERAL	156,074	145,174	301,248	4.00
5.00 PLANT OPERATION & MAINTENANCE	7,241	129,637	136,878	5.00
6.00 LAUNDRY & LINEN SERVICE	0	0	0	6.00
7.00 HOUSEKEEPING	0	49,517	49,517	7.00
8.00 DIETARY	0	0	0	8.00
9.00 NURSING ADMINISTRATION	0	80,009	80,009	9.00
10.00 ROUTINE MEDICAL SUPPLIES	243,007	1,565	244,572	10.00
11.00 MEDICAL RECORDS	0	0	0	11.00
12.00 STAFF TRANSPORTATION	0	0	0	12.00
13.00 VOLUNTEER SERVICE COORDINATION	0	0	0	13.00
14.00 PHARMACY	6,108	1,379	7,487	14.00
15.00 PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	15.00
16.00 OTHER GENERAL SERVICE	0	0	0	16.00
17.00 PATIENT/RESIDENTIAL CARE SERVICES	0	0	0	17.00
LEVEL OF CARE				
50.00 HOSPICE CONTINUOUS HOME CARE	0	0	0	50.00
51.00 HOSPICE ROUTINE HOME CARE	416,532	0	416,532	51.00
52.00 HOSPICE INPATIENT RESPIRE CARE	7,436	0	7,436	52.00
53.00 HOSPICE GENERAL INPATIENT CARE	42,697	0	42,697	53.00
NONREIMBURSABLE COST CENTERS				
60.00 BEREAVEMENT PROGRAM	0	0	0	60.00
61.00 VOLUNTEER PROGRAM	0	0	0	61.00
62.00 FUNDRAISING	0	0	0	62.00
63.00 HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	63.00
64.00 PALLIATIVE CARE PROGRAM	0	0	0	64.00
65.00 OTHER PHYSICIAN SERVICES	0	0	0	65.00
66.00 RESIDENTIAL CARE	0	0	0	66.00
67.00 ADVERTISING	0	0	0	67.00
68.00 TELEHEALTH/TELEMONITORING	0	0	0	68.00
69.00 THRIFT STORE	0	0	0	69.00
70.00 NURSING FACILITY ROOM & BOARD	0	0	0	70.00
71.00 OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	71.00
99.00 NEGATIVE COST CENTER	0	0	0	99.00
100.00 TOTAL	1,003,880	688,557	1,692,437	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 15-0042

Period: From 01/01/2022

Worksheet 0-6

Hospice CCN: 15-1526

To 12/31/2022

Part I
Date/Time Prepared:
5/24/2023 12:05 pm

Descriptions	TOTAL EXPENSES	CAP REL BLDG & FIX	CAP REL MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL	
	0	1.00	2.00	3.00	3A	
GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIX	114,958	114,958			1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2,530		2,530		2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	288,573	0	0	288,573	3.00
4.00	ADMINISTRATIVE & GENERAL	301,248	0	0	0	301,248
5.00	PLANT OPERATION & MAINTENANCE	136,878	0	0	0	136,878
6.00	LAUNDRY & LINEN SERVICE	0	0	0	0	0
7.00	HOUSEKEEPING	49,517	0	0	0	49,517
8.00	DIETARY	0	0	0	0	0
9.00	NURSING ADMINISTRATION	80,009	0	0	0	80,009
10.00	ROUTINE MEDICAL SUPPLIES	244,572	0	0	0	244,572
11.00	MEDICAL RECORDS	0	0	0	0	0
12.00	STAFF TRANSPORTATION	0	0	0	0	0
13.00	VOLUNTEER SERVICE COORDINATION	0	0	0	0	0
14.00	PHARMACY	7,487	0	0	0	7,487
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	0	0
16.00	OTHER GENERAL SERVICE	0	0	0	0	0
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0	0	0	0
LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0			0	0
51.00	HOSPICE ROUTINE HOME CARE	416,532			270,248	686,780
52.00	HOSPICE INPATIENT RESPIRE CARE	7,436	2,074	46	4,825	14,381
53.00	HOSPICE GENERAL INPATIENT CARE	42,697	112,884	2,484	13,500	171,565
NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0	0	0	0	0
61.00	VOLUNTEER PROGRAM	0	0	0	0	0
62.00	FUNDRAISING	0	0	0	0	0
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	0	0
64.00	PALLIATIVE CARE PROGRAM	0	0	0	0	0
65.00	OTHER PHYSICIAN SERVICES	0	0	0	0	0
66.00	RESIDENTIAL CARE	0	0	0	0	0
67.00	ADVERTISING	0	0	0	0	0
68.00	TELEHEALTH/TELEMONITORING	0	0	0	0	0
69.00	THRIFT STORE	0	0	0	0	0
70.00	NURSING FACILITY ROOM & BOARD	0				0
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0
99.00	NEGATIVE COST CENTER	0	0	0	0	0
100.00	TOTAL	1,692,437	114,958	2,530	288,573	1,692,437

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 15-0042

Period: From 01/01/2022

Worksheet 0-6

Hospice CCN: 15-1526

To 12/31/2022

Part I
Date/Time Prepared:
5/24/2023 12:05 pm

Descriptions	Hospice I					
	ADMINISTRATIVE & GENERAL	PLANT OPERATION & MAINTENANCE	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
	4.00	5.00	6.00	7.00	8.00	
GENERAL SERVICE COST CENTERS						
1.00 CAP REL COSTS-BLDG & FIXT						1.00
2.00 CAP REL COSTS-MVBLE EQUIP						2.00
3.00 EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00 ADMINISTRATIVE & GENERAL	301,248					4.00
5.00 PLANT OPERATION & MAINTENANCE	29,640	166,518				5.00
6.00 LAUNDRY & LINEN SERVICE	0	0	0			6.00
7.00 HOUSEKEEPING	10,722	0		60,239		7.00
8.00 DIETARY	0	0		0	0	8.00
9.00 NURSING ADMINISTRATION	17,325	0		0		9.00
10.00 ROUTINE MEDICAL SUPPLIES	52,960	0		0		10.00
11.00 MEDICAL RECORDS	0	0		0		11.00
12.00 STAFF TRANSPORTATION	0	0		0		12.00
13.00 VOLUNTEER SERVICE COORDINATION	0	0		0		13.00
14.00 PHARMACY	1,621	0		0		14.00
15.00 PHYSICIAN ADMINISTRATIVE SERVICES	0	0		0		15.00
16.00 OTHER GENERAL SERVICE	0	0		0		16.00
17.00 PATIENT/RESIDENTIAL CARE SERVICES	0	0		0		17.00
LEVEL OF CARE						
50.00 HOSPICE CONTINUOUS HOME CARE	0					50.00
51.00 HOSPICE ROUTINE HOME CARE	148,715					51.00
52.00 HOSPICE INPATIENT RESPIRE CARE	3,114	3,004	0	1,087	0	52.00
53.00 HOSPICE GENERAL INPATIENT CARE	37,151	163,514	0	59,152	0	53.00
NONREIMBURSABLE COST CENTERS						
60.00 BEREAVEMENT PROGRAM	0	0		0		60.00
61.00 VOLUNTEER PROGRAM	0	0		0		61.00
62.00 FUNDRAISING	0	0		0		62.00
63.00 HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0		0		63.00
64.00 PALLIATIVE CARE PROGRAM	0	0		0		64.00
65.00 OTHER PHYSICIAN SERVICES	0	0		0		65.00
66.00 RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00 ADVERTISING	0	0		0		67.00
68.00 TELEHEALTH/TELEMONITORING	0	0		0		68.00
69.00 THIRFT STORE	0	0		0		69.00
70.00 NURSING FACILITY ROOM & BOARD						70.00
71.00 OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00 NEGATIVE COST CENTER	0	0	0	0	0	99.00
100.00 TOTAL	301,248	166,518	0	60,239	0	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS		Provider CCN: 15-0042	Period: From 01/01/2022	Worksheet 0-6
		Hospice CCN: 15-1526	To 12/31/2022	Part I
				Date/Time Prepared: 5/24/2023 12:05 pm

Descriptions	Hospice I					
	NURSING ADMINISTRATIVE	ROUTINE MEDICAL SUPPLIES	MEDICAL RECORDS	STAFF TRANSPORTATION	VOLUNTEER SERVICE COORDINATION	
	9.00	10.00	11.00	12.00	13.00	
GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT					1.00
2.00	CAP REL COSTS-MVBLE EQUIP					2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT					3.00
4.00	ADMINISTRATIVE & GENERAL					4.00
5.00	PLANT OPERATION & MAINTENANCE					5.00
6.00	LAUNDRY & LINEN SERVICE					6.00
7.00	HOUSEKEEPING					7.00
8.00	DIETARY					8.00
9.00	NURSING ADMINISTRATION	97,334				9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	297,532			10.00
11.00	MEDICAL RECORDS	0		0		11.00
12.00	STAFF TRANSPORTATION	0			0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0			0	13.00
14.00	PHARMACY	0			0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0			0	15.00
16.00	OTHER GENERAL SERVICE	0			0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES					17.00
LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	91,158	278,639	0	0	51.00
52.00	HOSPICE INPATIENT RESPIRE CARE	1,625	4,974	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	4,551	13,919	0	0	53.00
NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0			0	60.00
61.00	VOLUNTEER PROGRAM	0			0	61.00
62.00	FUNDRAISING	0			0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0			0	63.00
64.00	PALLIATIVE CARE PROGRAM	0			0	64.00
65.00	OTHER PHYSICIAN SERVICES	0			0	65.00
66.00	RESIDENTIAL CARE	0			0	66.00
67.00	ADVERTISING	0			0	67.00
68.00	TELEHEALTH/TELEMONITORING	0			0	68.00
69.00	THRIFT STORE	0			0	69.00
70.00	NURSING FACILITY ROOM & BOARD					70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0			0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	99.00
100.00	TOTAL	97,334	297,532	0	0	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 15-0042

Period: From 01/01/2022

Worksheet 0-6

Hospice CCN: 15-1526

To 12/31/2022

Part I
Date/Time Prepared:
5/24/2023 12:05 pm

Descriptions	Hospice I				TOTAL	
	PHARMACY	PHYSICIAN ADMINISTRATIVE SERVICES	OTHER GENERAL SERVICE	PATIENT/ RESIDENTIAL CARE SERVICES		
	14.00	15.00	16.00	17.00	18.00	
GENERAL SERVICE COST CENTERS						
1.00						1.00
2.00						2.00
3.00						3.00
4.00						4.00
5.00						5.00
6.00						6.00
7.00						7.00
8.00						8.00
9.00						9.00
10.00						10.00
11.00						11.00
12.00						12.00
13.00						13.00
14.00	9,108					14.00
15.00	0	0				15.00
16.00	0		0			16.00
17.00				0		17.00
LEVEL OF CARE						
50.00	0	0	0		0	50.00
51.00	8,530	0	0		1,213,822	51.00
52.00	152	0	0	0	28,337	52.00
53.00	426	0	0	0	450,278	53.00
NONREIMBURSABLE COST CENTERS						
60.00	0		0		0	60.00
61.00	0		0		0	61.00
62.00	0		0		0	62.00
63.00	0		0		0	63.00
64.00	0		0		0	64.00
65.00	0		0		0	65.00
66.00	0	0	0	0	0	66.00
67.00	0		0		0	67.00
68.00	0		0		0	68.00
69.00	0		0		0	69.00
70.00						70.00
71.00	0	0	0	0	0	71.00
99.00	0	0	0	0	0	99.00
100.00	9,108	0	0	0	1,692,437	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS
STATISTICAL BASIS

Provider CCN: 15-0042
Hospice CCN: 15-1526

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

Worksheet 0-6
Part II
Date/Time Prepared:
5/24/2023 12:05 pm

Cost Center Descriptions		Hospice I		RECONCILIATION	ADMINISTRATIVE & GENERAL (ACCUMULATED COSTS)	
		CAP REL BLDG & FIX (SQUARE FEET)	CAP REL MVBLE EQUIP (DOLLAR VALUE)			
		1.00	2.00	3.00	4A	4.00
GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	388				1.00
2.00	CAP REL COSTS-MVBLE EQUIP		388			2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	513,669		3.00
4.00	ADMINISTRATIVE & GENERAL	0	0	0	-301,248	4.00
5.00	PLANT OPERATION & MAINTENANCE	0	0	0	0	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	0	6.00
7.00	HOUSEKEEPING	0	0	0	0	7.00
8.00	DIETARY	0	0	0	0	8.00
9.00	NURSING ADMINISTRATION	0	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0	0	0	10.00
11.00	MEDICAL RECORDS	0	0	0	0	11.00
12.00	STAFF TRANSPORTATION	0	0	0	0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0	0	0	13.00
14.00	PHARMACY	0	0	0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE	0	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0	0	0	17.00
LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE			0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE			481,050	0	51.00
52.00	HOSPICE INPATIENT RESPIRE CARE	7	7	8,588	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	381	381	24,031	0	53.00
NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM	0	0	0	0	61.00
62.00	FUNDRAISING	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0	0	0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	66.00
67.00	ADVERTISING	0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0	0	0	0	68.00
69.00	THRIFT STORE	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0	0	0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER					99.00
100.00	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	114,958	2,530	288,573		100.00
101.00	UNIT COST MULTIPLIER	296.283505	6.520619	0.561788		101.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS
STATISTICAL BASIS

Provider CCN: 15-0042
Hospice CCN: 15-1526

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

Worksheet 0-6
Part II
Date/Time Prepared:
5/24/2023 12:05 pm

Cost Center Descriptions		Hospice I					
		PLANT OPERATION & MAINTENANCE (SQUARE FEET)	LAUNDRY & LINEN SERVICE (IN-FACILITY DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (IN-FACILITY DAYS)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	
		5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE	388					5.00
6.00	LAUNDRY & LINEN SERVICE	0	0				6.00
7.00	HOUSEKEEPING	0		388			7.00
8.00	DIETARY	0		0	0		8.00
9.00	NURSING ADMINISTRATION	0		0		16,296	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0		0		0	10.00
11.00	MEDICAL RECORDS	0		0		0	11.00
12.00	STAFF TRANSPORTATION	0		0		0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0		0		0	13.00
14.00	PHARMACY	0		0		0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0		0		0	15.00
16.00	OTHER GENERAL SERVICE	0		0		0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0		0		0	17.00
LEVEL OF CARE							
50.00	HOSPICE CONTINUOUS HOME CARE					0	50.00
51.00	HOSPICE ROUTINE HOME CARE					15,262	51.00
52.00	HOSPICE INPATIENT RESPIRE CARE	7	0	7	0	272	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	381	0	381	0	762	53.00
NONREIMBURSABLE COST CENTERS							
60.00	BEREAVEMENT PROGRAM	0		0		0	60.00
61.00	VOLUNTEER PROGRAM	0		0		0	61.00
62.00	FUNDRAISING	0		0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0		0	63.00
64.00	PALLIATIVE CARE PROGRAM	0		0		0	64.00
65.00	OTHER PHYSICIAN SERVICES	0		0		0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0		0		0	67.00
68.00	TELEHEALTH/TELEMONITORING	0		0		0	68.00
69.00	THRIFT STORE	0		0		0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	166,518	0	60,239	0	97,334	100.00
101.00	UNIT COST MULTIPLIER	429.170103	0.000000	155.255155	0.000000	5.972877	101.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS
STATISTICAL BASIS

Provider CCN: 15-0042
Hospice CCN: 15-1526

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

Worksheet 0-6
Part II
Date/Time Prepared:
5/24/2023 12:05 pm

Cost Center Descriptions		Hospice I					
		ROUTINE MEDICAL SUPPLIES (PATIENT DAYS)	MEDICAL RECORDS (PATIENT DAYS)	STAFF TRANSPORTATION (MILEAGE)	VOLUNTEER SERVICE COORDINATION (HOURS OF SERVICE)	PHARMACY (CHARGES)	
		10.00	11.00	12.00	13.00	14.00	
GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION						9.00
10.00	ROUTINE MEDICAL SUPPLIES	7,118					10.00
11.00	MEDICAL RECORDS		0				11.00
12.00	STAFF TRANSPORTATION			0			12.00
13.00	VOLUNTEER SERVICE COORDINATION			0	0		13.00
14.00	PHARMACY			0	0	6,108	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES			0	0	0	15.00
16.00	OTHER GENERAL SERVICE			0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
LEVEL OF CARE							
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	6,666	0	0	0	5,720	51.00
52.00	HOSPICE INPATIENT RESPIRE CARE	119	0	0	0	102	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	333	0	0	0	286	53.00
NONREIMBURSABLE COST CENTERS							
60.00	BEREAVEMENT PROGRAM			0	0	0	60.00
61.00	VOLUNTEER PROGRAM			0	0	0	61.00
62.00	FUNDRAISING			0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS			0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM			0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES			0	0	0	65.00
66.00	RESIDENTIAL CARE			0	0	0	66.00
67.00	ADVERTISING			0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING			0	0	0	68.00
69.00	THRIFT STORE			0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD			0	0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)			0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	297,532	0	0	0	9,108	100.00
101.00	UNIT COST MULTIPLIER	41.799944	0.000000	0.000000	0.000000	1.491159	101.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS
STATISTICAL BASIS

Provider CCN: 15-0042
Hospice CCN: 15-1526

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

Worksheet 0-6
Part II
Date/Time Prepared:
5/24/2023 12:05 pm

Cost Center Descriptions		PHYSICIAN ADMINISTRATIVE SERVICES (PATIENT DAYS)	OTHER GENERAL SERVICE (SPECIFY BASIS)	PATIENT/ RESIDENTIAL CARE SERVICES (IN-FACILITY DAYS)	Hospice I	
		15.00	16.00	17.00		
GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT					1.00
2.00	CAP REL COSTS-MVBLE EQUIP					2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT					3.00
4.00	ADMINISTRATIVE & GENERAL					4.00
5.00	PLANT OPERATION & MAINTENANCE					5.00
6.00	LAUNDRY & LINEN SERVICE					6.00
7.00	HOUSEKEEPING					7.00
8.00	DIETARY					8.00
9.00	NURSING ADMINISTRATION					9.00
10.00	ROUTINE MEDICAL SUPPLIES					10.00
11.00	MEDICAL RECORDS					11.00
12.00	STAFF TRANSPORTATION					12.00
13.00	VOLUNTEER SERVICE COORDINATION					13.00
14.00	PHARMACY					14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0				15.00
16.00	OTHER GENERAL SERVICE		0			16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES			0		17.00
LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0			50.00
51.00	HOSPICE ROUTINE HOME CARE	0	0			51.00
52.00	HOSPICE INPATIENT RESPIRE CARE	0	0	0		52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0		53.00
NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM		0			60.00
61.00	VOLUNTEER PROGRAM		0			61.00
62.00	FUNDRAISING		0			62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS		0			63.00
64.00	PALLIATIVE CARE PROGRAM		0			64.00
65.00	OTHER PHYSICIAN SERVICES		0			65.00
66.00	RESIDENTIAL CARE	0	0	0		66.00
67.00	ADVERTISING		0			67.00
68.00	TELEHEALTH/TELEMONITORING		0			68.00
69.00	THRIFT STORE		0			69.00
70.00	NURSING FACILITY ROOM & BOARD		0			70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0		71.00
99.00	NEGATIVE COST CENTER		0			99.00
100.00	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)		0			100.00
101.00	UNIT COST MULTIPLIER	0.000000	0.000000	0.000000		101.00

APPORTIONMENT OF HOSPITAL-BASED HOSPICE SHARED SERVICE COSTS BY LEVEL OF CARE

Provider CCN: 15-0042
 Hospice CCN: 15-1526

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

Worksheet 0-7
 Date/Time Prepared:
 5/24/2023 12:05 pm

Cost Center Descriptions		From Wkst. C, Part I, Col. 9 line	Cost to Charge Ratio	Charges by LOC (from Provider Records)			
				HCHC	HRHC	HIRC	
				0	1.00	2.00	
ANCILLARY SERVICE COST CENTERS							
1.00	PHYSICAL THERAPY	66.00	0.358015	0	0	0	1.00
2.00	OCCUPATIONAL THERAPY	67.00					2.00
3.00	SPEECH PATHOLOGY	68.00					3.00
4.00	DRUGS CHARGED TO PATIENTS	73.00	0.326122	0	0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00	0.625858	0	0	0	5.00
6.00	LABORATORY	60.00	0.141685	0	0	0	6.00
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	1.374545	0	0	0	7.00
8.00	OTHER OUTPATIENT SERVICE COST CENTER	93.00					8.00
9.00	RADIOLOGY-THERAPEUTIC	55.00	0.217066	0	0	0	9.00
10.00	MH ANCILLARY OUTPATIENT	76.00	0.000000	0	0	0	10.00
10.01	INPATIENT DIALYSIS	76.01	0.925538	0	0	0	10.01
11.00	Totals (sum of lines 1-11)						11.00
Cost Center Descriptions		Charges by LOC (from Provider Records)	Shared Service Costs by LOC				
			HGIP	HCHC (col. 1 x col. 2)	HRHC (col. 1 x col. 3)	HIRC (col. 1 x col. 4)	HGIP (col. 1 x col. 5)
			5.00	6.00	7.00	8.00	9.00
ANCILLARY SERVICE COST CENTERS							
1.00	PHYSICAL THERAPY	0	0	0	0	0	1.00
2.00	OCCUPATIONAL THERAPY						2.00
3.00	SPEECH PATHOLOGY						3.00
4.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	5.00
6.00	LABORATORY	0	0	0	0	0	6.00
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	7.00
8.00	OTHER OUTPATIENT SERVICE COST CENTER						8.00
9.00	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	9.00
10.00	MH ANCILLARY OUTPATIENT	0	0	0	0	0	10.00
10.01	INPATIENT DIALYSIS	0	0	0	0	0	10.01
11.00	Totals (sum of lines 1-11)						11.00

CALCULATION OF HOSPITAL-BASED HOSPICE PER DIEM COST

Provider CCN: 15-0042

Period: From 01/01/2022

Worksheet 0-8

Hospice CCN: 15-1526

To 12/31/2022

Date/Time Prepared: 5/24/2023 12:05 pm

		Hospice I		
		TITLE XVII MEDI CARE	TITLE XIX MEDI CAID	TOTAL
		1.00	2.00	3.00
HOSPICE CONTINUOUS HOME CARE				
1.00	Total cost (Wkst. 0-6, Part I, col. 18, line 50 plus Wkst. 0-7, col. 6, line 11)			0
2.00	Total unduplicated days (Wkst. S-9, col. 4, line 10)			0
3.00	Total average cost per diem (line 1 divided by line 2)			0.00
4.00	Unduplicated program days (Wkst. S-9 col. as appropriate, line 10)			
5.00	Program cost (line 3 times line 4)	0	0	0
HOSPICE ROUTINE HOME CARE				
6.00	Total cost (Wkst. 0-6, Part I, col. 18, line 51 plus Wkst. 0-7, col. 7, line 11)			1,213,822
7.00	Total unduplicated days (Wkst. S-9, col. 4, line 11)			6,666
8.00	Total average cost per diem (line 6 divided by line 7)			182.09
9.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 11)	6,666	0	
10.00	Program cost (line 8 times line 9)	1,213,812	0	
HOSPICE INPATIENT RESPITE CARE				
11.00	Total cost (Wkst. 0-6, Part I, col. 18, line 52 plus Wkst. 0-7, col. 8, line 11)			28,337
12.00	Total unduplicated days (Wkst. S-9, col. 4, line 12)			119
13.00	Total average cost per diem (line 11 divided by line 12)			238.13
14.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 12)	7	10	
15.00	Program cost (line 13 times line 14)	1,667	2,381	
HOSPICE GENERAL INPATIENT CARE				
16.00	Total cost (Wkst. 0-6, Part I, col. 18, line 53 plus Wkst. 0-7, col. 9, line 11)			450,278
17.00	Total unduplicated days (Wkst. S-9, col. 4, line 13)			333
18.00	Total average cost per diem (line 16 divided by line 17)			1,352.19
19.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 13)	333	0	
20.00	Program cost (line 18 times line 19)	450,279	0	
TOTAL HOSPICE CARE				
21.00	Total cost (sum of line 1 + line 6 + line 11 + line 16)			1,692,437
22.00	Total unduplicated days (Wkst. S-9, col. 4, line 14)			7,118
23.00	Average cost per diem (line 21 divided by line 22)			237.77

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 15-0042	Period: From 01/01/2022 To 12/31/2022	Worksheet L Parts I-III Date/Time Prepared: 5/24/2023 12:05 pm
		Title XVIII	Hospital	PPS
				1.00
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		1,090,064	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		24,981	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)		43.63	3.00
4.00	Number of interns & residents (see instructions)		32.00	4.00
5.00	Indirect medical education percentage (see instructions)		23.00	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)		250,715	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		0.00	8.00
9.00	Sum of lines 7 and 8		0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)		0.00	10.00
11.00	Disproportionate share adjustment (see instructions)		0	11.00
12.00	Total prospective capital payments (see instructions)		1,365,760	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