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: 15-1328	Period: From 01/01/2022 To 12/31/2022	Worksheet S Parts I-III Date/Time Prepared: 5/30/2023 10:36 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 5/30/2023 Time: 10:36 am
2. [ ] Manually prepared cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no.

Contractor use only

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

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

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by INDIANA UNIVERSITY HEALTH BEDFORD (15-1328) 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	Michael Craig		Y	I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name	Michael Craig			2
3	Signatory Title	CHIEF FINANCIAL OFFICER			3
4	Date	(Dated when report is electronica			4

		Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	HOSPITAL	0	240,489	-916,509	0	0	1.00
2.00	SUBPROVIDER - IPF	0	0	0		0	2.00
3.00	SUBPROVIDER - IRF	0	0	0		0	3.00
5.00	SWING BED - SNF	0	0	0		0	5.00
6.00	SWING BED - NF	0				0	6.00
200.00	TOTAL	0	240,489	-916,509	0	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1328 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-2 Part I | Date/Time Prepared: 5/30/2023 10:36 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 2900 WEST SIXTEENTH STREET	PO Box:			1.00
2.00	City: BEDFORD	State: IN	Zip Code: 47421-	County: LAWRENCE	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	INDIANA UNIVERSITY HEALTH BEDFORD	151328	99915	1	10/01/2005	N	O	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	IU HEALTH BEDFORD - SWING BED	15Z328	99915		10/01/2005	N	O	O	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1328 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-2 Part I | Date/Time Prepared: 5/30/2023 10:36 am

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1328 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-2 Part I Date/Time Prepared: 5/30/2023 10:36 am

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1328 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-2 Part I Date/Time Prepared: 5/30/2023 10:36 am

		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
		1.00	2.00	3.00	
	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.				
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	64.00

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00

		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
		1.00	2.00	3.00	
	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010				
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	66.00

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

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

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

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

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

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

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

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1328 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-2 Part I | Date/Time Prepared: 5/30/2023 10:36 am

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	51,729	0	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	Y	5.00	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)	Y	15H059	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: INDIANA UNIVERSITY HEALTH, INC	Contractor's Name: WPS	Contractor's Number: 08101	141.00
142.00	Street: 340 WEST 10TH STREET	PO Box:		142.00
143.00	City: INDIANAPOLIS	State: IN	Zip Code: 46202	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: 15-1328 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-2 Part I Date/Time Prepared: 5/30/2023 10:36 am

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

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

			1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act			
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.		Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)			168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)			168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)		0.00	169.00
		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170.00
		1.00	2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	Y	159	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1328 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-2 Part II | Date/Time Prepared: 5/30/2023 10:36 am

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

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

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	02/23/2023	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	N		N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	04/03/2023	Y	04/03/2023	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1328 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-2 Part II Date/Time Prepared: 5/30/2023 10:36 am

		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00

		1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)		
	Capital Related Cost		
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions	N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.	N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions	N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.	N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.	N	27.00
	Interest Expense		
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.	N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions	N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	N	31.00
	Purchased Services		
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.	N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.	N	33.00
	Provider-Based Physicians		
34.00	Were services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.	Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.	N	35.00

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?	Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	Y		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	N		40.00

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	RHONDA	UTTER	41.00
42.00	Enter the employer/company name of the cost report preparer.	INDIANA UNIVERSITY HEALTH		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-962-1093	RUTTER@IUHEALTH.ORG	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-1328	Period: From 01/01/2022 To 12/31/2022	Worksheet S-2 Part II Date/Time Prepared: 5/30/2023 10:36 am

		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DIRECTOR		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: 15-1328 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-3 Part I | Date/Time Prepared: 5/30/2023 10:36 am

	Component	Worksheet A Line No.	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	40	14,600	143,712.00	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)		40	14,600	143,712.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	6	2,190	39,096.00	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						13.00
14.00	Total (see instructions)		46	16,790	182,808.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		46				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	21	7,665		0	34.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1328 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-3 Part I | Date/Time Prepared: 5/30/2023 10:36 am

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	2,756	167	5,988			1.00
2.00	HMO and other (see instructions)	1,917	815				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	2,756	167	5,988			7.00
8.00	INTENSIVE CARE UNIT	642	83	1,629			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)	3,398	250	7,617	0.00	253.52	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			101			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	253.52	27.00
28.00	Observation Bed Days		33	1,398			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care	0	0	0			34.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1328 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-3 Part I | Date/Time Prepared: 5/30/2023 10:36 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	756	48	1,631	1.00
2.00	HMO and other (see instructions)			392	168		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	756	48	1,631	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care						34.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-1328 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-10 | Date/Time Prepared: 5/30/2023 10:36 am

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.216913	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	8,341,727	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	N	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		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	58,565,058	6.00
7.00	Medicaid cost (line 1 times line 6)	12,703,522	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)	4,361,795	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)	11,641	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	116,678	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	25,309	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)	13,668	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)	4,375,463	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)	6,210,649	212,628	6,423,277	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	1,347,171	212,628	1,559,799	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	1,347,171	212,628	1,559,799	23.00

		1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	3,853,383	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	953,014	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	1,466,174	27.01
28.00	Non-Medicare bad debt expense (see instructions)	2,387,209	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	1,030,977	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	2,590,776	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	6,966,239	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1328 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A | Date/Time Prepared: 5/30/2023 10:36 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		0	0	507,458	507,458	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	1,587,885	1,587,885	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	88,970	88,970	3,695,725	3,784,695	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,601,523	15,922,885	17,524,408	-1,509,870	16,014,538	5.00
7.00	00700	OPERATION OF PLANT	703,248	4,231,483	4,934,731	-359,778	4,574,953	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	187,807	187,807	0	187,807	8.00
9.00	00900	HOUSEKEEPING	545,695	583,876	1,129,571	-139,430	990,141	9.00
10.00	01000	DIETARY	431,823	533,293	965,116	-343,386	621,730	10.00
11.00	01100	CAFETERIA	0	0	0	216,717	216,717	11.00
13.00	01300	NURSING ADMINISTRATION	2,911,337	754,780	3,666,117	-1,876,993	1,789,124	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	79,406	250,014	329,420	371,172	700,592	14.00
15.00	01500	PHARMACY	839,014	14,114,704	14,953,718	-13,300,833	1,652,885	15.00
17.00	01700	SOCIAL SERVICE	0	0	0	53,157	53,157	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,960,720	3,287,529	7,248,249	458,456	7,706,705	30.00
31.00	03100	INTENSIVE CARE UNIT	1,915,710	1,013,807	2,929,517	-215,267	2,714,250	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,252,566	2,180,493	3,433,059	-897,441	2,535,618	50.00
51.00	05100	RECOVERY ROOM	436,837	132,821	569,658	-35,915	533,743	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,178,619	1,297,542	2,476,161	-651,569	1,824,592	54.00
56.00	05600	RADIOISOTOPE	97,546	191,544	289,090	-106,436	182,654	56.00
57.00	05700	CT SCAN	443,176	503,535	946,711	-438,214	508,497	57.00
58.00	05800	MRI	263,563	216,450	480,013	-102,825	377,188	58.00
60.00	06000	LABORATORY	309,630	4,525,535	4,835,165	-28,279	4,806,886	60.00
65.00	06500	RESPIRATORY THERAPY	1,083,914	463,465	1,547,379	79,218	1,626,597	65.00
66.00	06600	PHYSICAL THERAPY	723,856	291,579	1,015,435	-132,777	882,658	66.00
67.00	06700	OCCUPATIONAL THERAPY	324,831	79,429	404,260	-55,509	348,751	67.00
68.00	06800	SPEECH PATHOLOGY	164,336	40,241	204,577	-26,949	177,628	68.00
69.00	06900	ELECTROCARDIOLOGY	467,469	975,189	1,442,658	-298,945	1,143,713	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	284,190	284,190	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	138,554	138,554	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	13,559,570	13,559,570	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	94,328	94,328	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,064,606	517,092	1,581,698	-225,968	1,355,730	90.00
90.01	09001	CLINIC - DIABETES	0	43,569	43,569	-157	43,412	90.01
91.00	09100	EMERGENCY	3,643,004	3,227,852	6,870,856	-345,016	6,525,840	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	24,442,429	55,655,484	80,097,913	-45,127	80,052,786	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	28,956	18,990	47,946	-16,808	31,138	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	193	2,214	2,407	63,389	65,796	192.00
194.00	07950	OCCUPATIONAL HEALTH	0	5,789	5,789	-1,429	4,360	194.00
194.02	07952	BLOOMNGTN AMBULANCE AND OCC MED	824	725	1,549	-25	1,524	194.02
194.03	07953	HOME CARE	0	0	0	0	0	194.03
200.00		TOTAL (SUM OF LINES 118 through 199)	24,472,402	55,683,202	80,155,604	0	80,155,604	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1328 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A | Date/Time Prepared: 5/30/2023 10:36 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	293,332	800,790		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	262,406	1,850,291		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	50,085	3,834,780		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-1,801,557	14,212,981		5.00
7.00	00700	OPERATION OF PLANT	31,388	4,606,341		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	-890	186,917		8.00
9.00	00900	HOUSEKEEPING	0	990,141		9.00
10.00	01000	DIETARY	-14,279	607,451		10.00
11.00	01100	CAFETERIA	0	216,717		11.00
13.00	01300	NURSING ADMINISTRATION	144,097	1,933,221		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	700,592		14.00
15.00	01500	PHARMACY	306,186	1,959,071		15.00
17.00	01700	SOCIAL SERVICE	0	53,157		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-1,329,001	6,377,704		30.00
31.00	03100	INTENSIVE CARE UNIT	-332,430	2,381,820		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-879,282	1,656,336		50.00
51.00	05100	RECOVERY ROOM	0	533,743		51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-54,953	1,769,639		54.00
56.00	05600	RADIOISOTOPE	-3,503	179,151		56.00
57.00	05700	CT SCAN	0	508,497		57.00
58.00	05800	MRI	0	377,188		58.00
60.00	06000	LABORATORY	-309,629	4,497,257		60.00
65.00	06500	RESPIRATORY THERAPY	-90,240	1,536,357		65.00
66.00	06600	PHYSICAL THERAPY	94,109	976,767		66.00
67.00	06700	OCCUPATIONAL THERAPY	-11,850	336,901		67.00
68.00	06800	SPEECH PATHOLOGY	0	177,628		68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,143,713		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	284,190		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	138,554		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	13,559,570		73.00
76.97	07697	CARDIAC REHABILITATION	0	94,328		76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	-418	1,355,312		90.00
90.01	09001	CLINIC - DIABETES	-43,412	0		90.01
91.00	09100	EMERGENCY	249,547	6,775,387		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-3,440,294	76,612,492		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	31,138		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	65,796		192.00
194.00	07950	OCCUPATIONAL HEALTH	0	4,360		194.00
194.02	07952	BLOOMNGTN AMBULANCE AND OCC MED	0	1,524		194.02
194.03	07953	HOME CARE	0	0		194.03
200.00		TOTAL (SUM OF LINES 118 through 199)	-3,440,294	76,715,310		200.00

RECLASSIFICATIONS | Provider CCN: 15-1328 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-6 | Date/Time Prepared: 5/30/2023 10:36 am

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - BENEFITS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	3,695,841		1.00
2.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	303		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
	0		0	3,696,144		
	B - DIETARY/CAFETERIA					
1.00	CAFETERIA	11.00	100,442	116,275		1.00
	0		100,442	116,275		
	C - CAPITAL LEASE					
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	63,283		1.00
	0		0	63,283		
	D - CARDIOLOGY					
1.00	CARDIAC REHABILITATION	76.97	74,789	19,539		1.00
	0		74,789	19,539		
	E - DEPR EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	445,317		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	1,569,557		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
	0		0	2,014,874		
	F - BILLABLE DRUGS					
1.00	DRUGS CHARGED TO PATIENTS	73.00		13,559,570		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

RECLASSIFICATIONS | Provider CCN: 15-1328 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-6 | Date/Time Prepared: 5/30/2023 10:36 am

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
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
	0		0	13,559,570		
	G - IMPLANT SUPPLIES					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00		138,554		1.00
2.00	CENTRAL SERVICES & SUPPLY	14.00		555		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
	0		0	139,109		
	I - BILLABLE MEDICAL SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00		284,190		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
	0		0	284,190		
	J - PROPERTY INSURANCE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	61,673		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	18,328		2.00
	0		0	80,001		
	K - PROPERTY TAXES					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	468		1.00
	TOTALS		0	468		
	L - SOCIAL WORKER					
1.00	SOCIAL SERVICE	17.00	53,157	0		1.00
	0		53,157	0		
	M - NONBILLABLE DRUGS					
1.00	PHARMACY	15.00	0	275,396		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
	0		0	275,396		
	N - NONBILLABLE MEDICAL SUPPLIES					
1.00	CENTRAL SERVICES & SUPPLY	14.00		450,282		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00		20,184		2.00
3.00	OPERATION OF PLANT	7.00		12,221		3.00
4.00	HOUSEKEEPING	9.00		481		4.00
5.00	DIETARY	10.00		40		5.00
6.00	NURSING ADMINISTRATION	13.00		767		6.00
7.00	RADIOISOTOPE	56.00		5,091		7.00
8.00	CT SCAN	57.00		4,170		8.00
9.00	LABORATORY	60.00		1		9.00
10.00	PHYSICAL THERAPY	66.00		900		10.00
11.00	BLOOMNGTN AMBULANCE AND OCC MED	194.02		8		11.00
12.00		0.00	0	0		12.00
	0		0	494,145		

RECLASSIFICATIONS | Provider CCN: 15-1328 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-6 | Date/Time Prepared: 5/30/2023 10:36 am

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	O - PREMIUM WAGES				
1.00	ADULTS & PEDIATRICS	30.00	878,680	67,685	1.00
2.00	RESPIRATORY THERAPY	65.00	216,381	16,668	2.00
3.00	EMERGENCY	91.00	272,829	21,016	3.00
	0		1,367,890	105,369	
	P - COMMUNITY BENEFIT				
1.00	OCCUPATIONAL HEALTH	194.00	0	1,290	1.00
	0		0	1,290	
	Q - SPOT RETENTION BONUS				
1.00	ADULTS & PEDIATRICS	30.00	256,322	19,609	1.00
2.00	INTENSIVE CARE UNIT	31.00	145,675	11,144	2.00
3.00	OPERATING ROOM	50.00	66,145	5,060	3.00
4.00	RECOVERY ROOM	51.00	52,114	3,987	4.00
5.00	RESPIRATORY THERAPY	65.00	94,994	7,267	5.00
6.00	ELECTROCARDIOLOGY	69.00	34,075	2,607	6.00
7.00	CLINIC	90.00	83,183	6,363	7.00
8.00	EMERGENCY	91.00	221,492	16,944	8.00
	TOTALS		954,000	72,981	
500.00	Grand Total: Increases		2,550,278	20,922,634	500.00

RECLASSIFICATIONS | Provider CCN: 15-1328 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-6 | Date/Time Prepared: 5/30/2023 10:36 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - BENEFITS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	129,019	0		1.00
2.00	OPERATION OF PLANT	7.00	0	169,133	0		2.00
3.00	HOUSEKEEPING	9.00	0	117,576	0		3.00
4.00	DIETARY	10.00	0	112,623	0		4.00
5.00	NURSING ADMINISTRATION	13.00	0	326,777	0		5.00
6.00	CENTRAL SERVICES & SUPPLY	14.00	0	52,295	0		6.00
7.00	PHARMACY	15.00	0	151,598	0		7.00
8.00	ADULTS & PEDIATRICS	30.00	0	554,537	0		8.00
9.00	INTENSIVE CARE UNIT	31.00	0	254,919	0		9.00
10.00	OPERATING ROOM	50.00	0	168,225	0		10.00
11.00	RECOVERY ROOM	51.00	0	76,105	0		11.00
12.00	RADIOLOGY-DIAGNOSTIC	54.00	0	230,631	0		12.00
13.00	RADIOISOTOPE	56.00	0	25,684	0		13.00
14.00	CT SCAN	57.00	0	80,250	0		14.00
15.00	MRI	58.00	0	44,616	0		15.00
16.00	LABORATORY	60.00	0	28,280	0		16.00
17.00	RESPIRATORY THERAPY	65.00	0	144,146	0		17.00
18.00	PHYSICAL THERAPY	66.00	0	127,500	0		18.00
19.00	OCCUPATIONAL THERAPY	67.00	0	55,509	0		19.00
20.00	SPEECH PATHOLOGY	68.00	0	26,949	0		20.00
21.00	ELECTROCARDIOLOGY	69.00	0	56,377	0		21.00
22.00	CLINIC	90.00	0	215,112	0		22.00
23.00	EMERGENCY	91.00	0	531,442	0		23.00
24.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00	0	16,808	0		24.00
25.00	BLOOMNGTN AMBULANCE AND OCC MED	194.02	0	33	0		25.00
	0		0	3,696,144			
	B - DIETARY/CAFETERIA						
1.00	DIETARY	10.00	100,442	116,275	0		1.00
	0		100,442	116,275			
	C - CAPITAL LEASE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	63,283	0		1.00
	0		0	63,283			
	D - CARDIOLOGY						
1.00	ELECTROCARDIOLOGY	69.00	74,789	19,539	0		1.00
	0		74,789	19,539			
	E - DEPR EXPENSE						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	116	9		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	227,097	9		2.00
3.00	OPERATION OF PLANT	7.00	0	202,866	0		3.00
4.00	HOUSEKEEPING	9.00	0	22,335	0		4.00
5.00	DIETARY	10.00	0	14,070	0		5.00
6.00	NURSING ADMINISTRATION	13.00	0	22,910	0		6.00
7.00	CENTRAL SERVICES & SUPPLY	14.00	0	22,912	0		7.00
8.00	PHARMACY	15.00	0	97,779	0		8.00
9.00	ADULTS & PEDIATRICS	30.00	0	59,751	0		9.00
10.00	INTENSIVE CARE UNIT	31.00	0	48,198	0		10.00
11.00	OPERATING ROOM	50.00	0	291,624	0		11.00
12.00	RECOVERY ROOM	51.00	0	15,426	0		12.00
13.00	RADIOLOGY-DIAGNOSTIC	54.00	0	356,953	0		13.00
14.00	RADIOISOTOPE	56.00	0	84,326	0		14.00
15.00	CT SCAN	57.00	0	243,557	0		15.00
16.00	MRI	58.00	0	29,726	0		16.00
17.00	RESPIRATORY THERAPY	65.00	0	46,832	0		17.00
18.00	PHYSICAL THERAPY	66.00	0	4,744	0		18.00
19.00	ELECTROCARDIOLOGY	69.00	0	109,268	0		19.00
20.00	CLINIC	90.00	0	6,474	0		20.00
21.00	CLINIC - DIABETES	90.01	0	157	0		21.00
22.00	EMERGENCY	91.00	0	107,745	0		22.00
23.00	OCCUPATIONAL HEALTH	194.00	0	8	0		23.00
	0		0	2,014,874			
	F - BILLABLE DRUGS						
1.00	ADMINISTRATIVE & GENERAL	5.00		1,915	0		1.00
2.00	NURSING ADMINISTRATION	13.00		756	0		2.00
3.00	CENTRAL SERVICES & SUPPLY	14.00		817	0		3.00
4.00	PHARMACY	15.00		13,309,921	0		4.00
5.00	ADULTS & PEDIATRICS	30.00		4,252	0		5.00
6.00	INTENSIVE CARE UNIT	31.00		1,757	0		6.00
7.00	OPERATING ROOM	50.00		7,262	0		7.00
8.00	RADIOLOGY-DIAGNOSTIC	54.00		13,684	0		8.00
9.00	RADIOISOTOPE	56.00		342	0		9.00
10.00	CT SCAN	57.00		118,063	0		10.00

RECLASSIFICATIONS | Provider CCN: 15-1328 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-6 | Date/Time Prepared: 5/30/2023 10:36 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
11.00	MRI	58.00		26,707	0		11.00
12.00	RESPIRATORY THERAPY	65.00		2,162	0		12.00
13.00	PHYSICAL THERAPY	66.00		55	0		13.00
14.00	ELECTROCARDIOLOGY	69.00		62,359	0		14.00
15.00	CLINIC	90.00		249	0		15.00
16.00	EMERGENCY	91.00		6,558	0		16.00
17.00	OCCUPATIONAL HEALTH	194.00		2,711	0		17.00
	0		0	13,559,570			
	G - IMPLANT SUPPLIES						
1.00	PHARMACY	15.00		218	0		1.00
2.00	ADULTS & PEDIATRICS	30.00		836	0		2.00
3.00	INTENSIVE CARE UNIT	31.00		239	0		3.00
4.00	OPERATING ROOM	50.00		99,956	0		4.00
5.00	CLINIC	90.00		35,010	0		5.00
6.00	EMERGENCY	91.00		2,850	0		6.00
	0		0	139,109			
	I - BILLABLE MEDICAL SUPPLIES						
1.00	DIETARY	10.00		16	0		1.00
2.00	CENTRAL SERVICES & SUPPLY	14.00		1,714	0		2.00
3.00	PHARMACY	15.00		3,782	0		3.00
4.00	ADULTS & PEDIATRICS	30.00		20,883	0		4.00
5.00	INTENSIVE CARE UNIT	31.00		6,376	0		5.00
6.00	OPERATING ROOM	50.00		216,594	0		6.00
7.00	RADIOLOGY-DIAGNOSTIC	54.00		1,869	0		7.00
8.00	RADIOISOTOPE	56.00		65	0		8.00
9.00	CT SCAN	57.00		9	0		9.00
10.00	MRI	58.00		24	0		10.00
11.00	RESPIRATORY THERAPY	65.00		677	0		11.00
12.00	PHYSICAL THERAPY	66.00		1,378	0		12.00
13.00	ELECTROCARDIOLOGY	69.00		206	0		13.00
14.00	CLINIC	90.00		10,755	0		14.00
15.00	EMERGENCY	91.00		19,822	0		15.00
16.00	PHYSICIANS' PRIVATE OFFICES	192.00		20	0		16.00
	0		0	284,190			
	J - PROPERTY INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	80,001	12		1.00
2.00		0.00	0	0	12		2.00
	0		0	80,001			
	K - PROPERTY TAXES						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	468	13		1.00
	TOTALS		0	468			
	L - SOCIAL WORKER						
1.00	NURSING ADMINISTRATION	13.00	53,157	0	0		1.00
	0		53,157	0			
	M - NONBILLABLE DRUGS						
1.00	NURSING ADMINISTRATION	13.00		901	0		1.00
2.00	CENTRAL SERVICES & SUPPLY	14.00		1,927	0		2.00
3.00	ADULTS & PEDIATRICS	30.00		37,523	0		3.00
4.00	INTENSIVE CARE UNIT	31.00		27,038	0		4.00
5.00	OPERATING ROOM	50.00		27,757	0		5.00
6.00	RECOVERY ROOM	51.00		292	0		6.00
7.00	RADIOLOGY-DIAGNOSTIC	54.00		16,812	0		7.00
8.00	RADIOISOTOPE	56.00		1,110	0		8.00
9.00	CT SCAN	57.00		505	0		9.00
10.00	ELECTROCARDIOLOGY	69.00		2,335	0		10.00
11.00	CLINIC	90.00		35,402	0		11.00
12.00	EMERGENCY	91.00		123,794	0		12.00
	0		0	275,396			
	N - NONBILLABLE MEDICAL SUPPLIES						
1.00	PHARMACY	15.00	0	12,931	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	86,058	0		2.00
3.00	INTENSIVE CARE UNIT	31.00	0	33,559	0		3.00
4.00	OPERATING ROOM	50.00	0	157,228	0		4.00
5.00	RECOVERY ROOM	51.00	0	193	0		5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00	0	31,620	0		6.00
7.00	MRI	58.00	0	1,752	0		7.00
8.00	RESPIRATORY THERAPY	65.00	0	62,275	0		8.00
9.00	ELECTROCARDIOLOGY	69.00	0	10,754	0		9.00
10.00	CLINIC	90.00	0	12,512	0		10.00
11.00	EMERGENCY	91.00	0	85,086	0		11.00
12.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	177	0		12.00
	0		0	494,145			

RECLASSIFICATIONS | Provider CCN: 15-1328 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-6 | Date/Time Prepared: 5/30/2023 10:36 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	O - PREMIUM WAGES						
1.00	NURSING ADMINISTRATION	13.00	1,367,890	105,369	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	0		1,367,890	105,369			
	P - COMMUNITY BENEFIT						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	1,290	0		1.00
	0		0	1,290			
	Q - SPOT RETENTION BONUS						
1.00	ADMINISTRATIVE & GENERAL	5.00	954,000	72,981	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
	TOTALS		954,000	72,981			
500.00	Grand Total: Decreases		2,550,278	20,922,634			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1328 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-7 Part I | Date/Time Prepared: 5/30/2023 10:36 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	931,334	102,987	0	102,987	0	1.00
2.00	Land Improvements	1,119,735	0	0	0	26,388	2.00
3.00	Buildings and Fixtures	14,066,348	0	0	0	158,931	3.00
4.00	Building Improvements	5,815,759	407,604	0	407,604	12,167	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	16,138,084	3,714,718	0	3,714,718	464,115	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	38,071,260	4,225,309	0	4,225,309	661,601	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	38,071,260	4,225,309	0	4,225,309	661,601	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	1,034,321	0	1.00
2.00	Land Improvements	1,093,347	943,950	2.00
3.00	Buildings and Fixtures	13,907,417	5,416,377	3.00
4.00	Building Improvements	6,211,196	2,472,253	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	19,388,687	9,676,817	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	41,634,968	18,509,397	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	41,634,968	18,509,397	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1328 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-7 Part II Date/Time Prepared: 5/30/2023 10:36 am

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

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

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1328 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-7 Part III Date/Time Prepared: 5/30/2023 10:36 am

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: 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	22,246,281	0	22,246,281	0.534317	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	19,388,688	0	19,388,688	0.465683	0	2.00
3.00	Total (sum of lines 1-2)	41,634,969	0	41,634,969	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: 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	445,317	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	1,831,963	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	2,277,280	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: 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	293,332	61,673	468	0	800,790	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	18,328	0	0	1,850,291	2.00
3.00	Total (sum of lines 1-2)	293,332	80,001	468	0	2,651,081	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1328 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-8 | Date/Time Prepared: 5/30/2023 10:36 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-869,394	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)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-5,038,479			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	11,000,413			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	0	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	A	-21	CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00	MISCELLANEOUS INCOME	B	-44,349	ADMINISTRATIVE & GENERAL	5.00	0	33.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1328 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-8 | Date/Time Prepared: 5/30/2023 10:36 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
34.00	MISCELLANEOUS INCOME	B	-142	OPERATION OF PLANT	7.00	0	34.00
35.00	MISCELLANEOUS INCOME	B	-890	LAUNDRY & LINEN SERVICE	8.00	0	35.00
36.00	MISCELLANEOUS INCOME	B	-69	PHARMACY	15.00	0	36.00
37.00	MISCELLANEOUS INCOME	B	-89,083	RESPIRATORY THERAPY	65.00	0	37.00
38.00	MISCELLANEOUS INCOME	B	-11,850	OCCUPATIONAL THERAPY	67.00	0	38.00
39.00	UNWONTED SITUATIONS	A	-343	EMERGENCY	91.00	0	39.00
45.00	TELEPHONE EXPENSE	A	-1,157	RESPIRATORY THERAPY	65.00	0	45.00
45.01	INVESTMENT FEES	B	9,762	ADMINISTRATIVE & GENERAL	5.00	0	45.01
45.02	PHONES	A	-2,935	CAP REL COSTS-MVBLE EQUIP	2.00	9	45.02
45.03	HAF	A	-4,657,188	ADMINISTRATIVE & GENERAL	5.00	0	45.03
45.04	MARKETING	A	-12,266	ADMINISTRATIVE & GENERAL	5.00	0	45.04
45.05	MARKETING	A	-418	CLINIC	90.00	0	45.05
45.06	BENEFITS	A	-3,695,841	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	45.06
45.07	CONTRIBUTION EXPENSE	A	-770	ADMINISTRATIVE & GENERAL	5.00	0	45.07
45.08	CONTRIBUTION EXPENSE	A	-21,323	RADIOLOGY-DIAGNOSTIC	54.00	0	45.08
45.09	CONTRIBUTION EXPENSE	A	-3,503	RADIOISOTOPE	56.00	0	45.09
45.10	DIABETES CLINIC	A	-448	CLINIC - DIABETES	90.01	0	45.10
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-3,440,294				50.00

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.
(2) Basis for adjustment (see instructions).
A. Costs - if cost, including applicable overhead, can be determined.
B. Amount Received - if cost cannot be determined.
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.
Note: See instructions for column 5 referencing to Worksheet A-7.

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 15-1328 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-8-1 | Date/Time Prepared: 5/30/2023 10:36 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.00	CAP REL COSTS-BLDG & FIXT	HOME OFFICE	1,162,726	0	1.00
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	HOME OFFICE	265,362	0	2.00
3.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE	3,699,650	0	3.00
4.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE	11,037,161	9,206,109	4.00
4.01	4.00	EMPLOYEE BENEFITS DEPARTMENT	RELATED PARTY	126,328	80,052	4.01
4.02	5.00	ADMINISTRATIVE & GENERAL	RELATED PARTY	1,862,187	789,985	4.02
4.03	7.00	OPERATION OF PLANT	RELATED PARTY	31,530	0	4.03
4.04	10.00	DIETARY	RELATED PARTY	0	14,279	4.04
4.05	13.00	NURSING ADMINISTRATION	RELATED PARTY	215,986	71,889	4.05
4.06	15.00	PHARMACY	RELATED PARTY	691,450	385,195	4.06
4.07	54.00	RADIOLOGY-DIAGNOSTIC	RELATED PARTY	112,687	0	4.07
4.08	66.00	PHYSICAL THERAPY	RELATED PARTY	172,792	78,683	4.08
4.09	90.01	CLINIC - DIABETES	RELATED PARTY	0	42,964	4.09
4.10	91.00	EMERGENCY	EMERGENCY ROOM	3,005,025	713,315	4.10
4.11	4.00	EMPLOYEE BENEFITS DEPARTMENT	SHARED EMPLOYEES	2,747	2,747	4.11
4.12	5.00	ADMINISTRATIVE & GENERAL	SHARED EMPLOYEES	32,119	32,119	4.12
4.13	10.00	DIETARY	SHARED EMPLOYEES	30,986	30,986	4.13
4.14	15.00	PHARMACY	SHARED EMPLOYEES	24	24	4.14
4.15	30.00	ADULTS & PEDIATRICS	SHARED EMPLOYEES	1,329,001	1,329,001	4.15
4.16	31.00	INTENSIVE CARE UNIT	SHARED EMPLOYEES	332,430	332,430	4.16
4.17	60.00	LABORATORY	SHARED EMPLOYEES	4,120,382	4,120,382	4.17
4.20	69.00	ELECTROCARDIOLOGY	SHARED EMPLOYEES	571,735	571,735	4.20
4.21	90.00	CLINIC	SHARED EMPLOYEES	57,667	57,667	4.21
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			28,859,975	17,859,562	5.00

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

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

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

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

6.00	B		0.00	IU HEALTH, INC.	50.00	6.00
7.00	F		0.00	IUH BLOOMINGTO	50.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 15-1328 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-8-1 | Date/Time Prepared: 5/30/2023 10:36 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	1,162,726	11		1.00
2.00	265,362	9		2.00
3.00	3,699,650	0		3.00
4.00	1,831,052	0		4.00
4.01	46,276	0		4.01
4.02	1,072,202	0		4.02
4.03	31,530	0		4.03
4.04	-14,279	0		4.04
4.05	144,097	0		4.05
4.06	306,255	0		4.06
4.07	112,687	0		4.07
4.08	94,109	0		4.08
4.09	-42,964	0		4.09
4.10	2,291,710	0		4.10
4.11	0	0		4.11
4.12	0	0		4.12
4.13	0	0		4.13
4.14	0	0		4.14
4.15	0	0		4.15
4.16	0	0		4.16
4.17	0	0		4.17
4.20	0	0		4.20
4.21	0	0		4.21
5.00	11,000,413			5.00

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

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

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

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

6.00	HOME OFFICE		6.00
7.00	HEALTHCARE		7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-1328 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-8-2 | Date/Time Prepared: 5/30/2023 10:36 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	1,329,001	1,329,001	0	0	0	1.00
2.00	31.00	INTENSIVE CARE UNIT	332,430	332,430	0	0	0	2.00
3.00	50.00	OPERATING ROOM	879,282	879,282	0	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	146,317	146,317	0	0	0	4.00
5.00	60.00	LABORATORY	309,629	309,629	0	0	0	5.00
6.00	91.00	EMERGENCY	2,755,135	2,041,820	713,315	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			5,751,794	5,038,479	713,315		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	31.00	INTENSIVE CARE UNIT	0	0	0	0	0	2.00
3.00	50.00	OPERATING ROOM	0	0	0	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	4.00
5.00	60.00	LABORATORY	0	0	0	0	0	5.00
6.00	91.00	EMERGENCY	0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	1,329,001		1.00
2.00	31.00	INTENSIVE CARE UNIT	0	0	0	332,430		2.00
3.00	50.00	OPERATING ROOM	0	0	0	879,282		3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	146,317		4.00
5.00	60.00	LABORATORY	0	0	0	309,629		5.00
6.00	91.00	EMERGENCY	0	0	0	2,041,820		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	5,038,479		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1328 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part I | Date/Time Prepared: 5/30/2023 10:36 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	800,790	800,790				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,850,291		1,850,291			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,834,780	2,232	7,046	3,844,058		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	14,212,981	109,976	347,208	101,711	14,771,876	5.00
7.00	00700	OPERATION OF PLANT	4,606,341	88,110	278,173	110,464	5,083,088	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	186,917	3,365	10,623	0	200,905	8.00
9.00	00900	HOUSEKEEPING	990,141	7,648	24,145	85,716	1,107,650	9.00
10.00	01000	DIETARY	607,451	18,081	57,084	52,052	734,668	10.00
11.00	01100	CAFETERIA	216,717	8,120	25,636	15,777	266,250	11.00
13.00	01300	NURSING ADMINISTRATION	1,933,221	26,296	83,018	234,090	2,276,625	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	700,592	18,540	58,534	12,473	790,139	14.00
15.00	01500	PHARMACY	1,959,071	6,335	19,999	131,790	2,117,195	15.00
17.00	01700	SOCIAL SERVICE	53,157	1,240	3,916	8,350	66,663	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,377,704	49,694	156,891	800,429	7,384,718	30.00
31.00	03100	INTENSIVE CARE UNIT	2,381,820	13,395	42,288	323,796	2,761,299	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,656,336	52,789	166,660	207,139	2,082,924	50.00
51.00	05100	RECOVERY ROOM	533,743	0	0	76,803	610,546	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,769,639	27,188	85,837	185,134	2,067,798	54.00
56.00	05600	RADIOISOTOPE	179,151	0	0	15,322	194,473	56.00
57.00	05700	CT SCAN	508,497	4,751	14,999	69,613	597,860	57.00
58.00	05800	MRI	377,188	4,554	14,376	41,400	437,518	58.00
60.00	06000	LABORATORY	4,497,257	19,802	62,518	48,636	4,628,213	60.00
65.00	06500	RESPIRATORY THERAPY	1,536,357	9,154	28,901	219,168	1,793,580	65.00
66.00	06600	PHYSICAL THERAPY	976,767	10,223	32,275	113,701	1,132,966	66.00
67.00	06700	OCCUPATIONAL THERAPY	336,901	5,210	16,449	51,023	409,583	67.00
68.00	06800	SPEECH PATHOLOGY	177,628	1,777	5,610	25,813	210,828	68.00
69.00	06900	ELECTROCARDIOLOGY	1,143,713	23,424	73,954	67,033	1,308,124	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	284,190	0	0	0	284,190	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	138,554	0	0	0	138,554	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	13,559,570	0	0	0	13,559,570	73.00
76.97	07697	CARDIAC REHABILITATION	94,328	1,730	5,460	11,748	113,266	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,355,312	32,287	101,934	180,291	1,669,824	90.00
90.01	09001	CLINIC - DIABETES	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	6,775,387	24,995	78,913	649,879	7,529,174	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	76,612,492	570,916	1,802,447	3,839,351	76,330,067	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	31,138	4,073	12,859	4,548	52,618	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	65,796	187,326	0	30	253,152	192.00
194.00	07950	OCCUPATIONAL HEALTH	4,360	11,081	34,985	0	50,426	194.00
194.02	07952	BLOOMNGTN AMBULANCE AND OCC MED	1,524	27,394	0	129	29,047	194.02
194.03	07953	HOME CARE	0	0	0	0	0	194.03
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)	76,715,310	800,790	1,850,291	3,844,058	76,715,310	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1328 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part I | Date/Time Prepared: 5/30/2023 10:36 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	14,771,876					5.00
7.00	00700	OPERATION OF PLANT	1,212,184	6,295,272				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	47,911	35,275	284,091			8.00
9.00	00900	HOUSEKEEPING	264,146	80,180	0	1,451,976		9.00
10.00	01000	DIETARY	175,199	189,561	0	70,058	1,169,486	10.00
11.00	01100	CAFETERIA	63,494	85,129	0	31,462	0	11.00
13.00	01300	NURSING ADMINISTRATION	542,916	275,679	0	101,886	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	188,428	194,375	0	71,837	0	14.00
15.00	01500	PHARMACY	504,896	66,411	0	24,544	0	15.00
17.00	01700	SOCIAL SERVICE	15,897	13,003	0	4,806	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,761,063	520,988	223,334	192,547	919,375	30.00
31.00	03100	INTENSIVE CARE UNIT	658,498	140,427	60,757	51,899	250,111	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	496,723	553,429	0	204,537	0	50.00
51.00	05100	RECOVERY ROOM	145,599	0	0	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	493,116	285,038	0	105,345	0	54.00
56.00	05600	RADIOISOTOPE	46,377	0	0	0	0	56.00
57.00	05700	CT SCAN	142,574	49,809	0	18,408	0	57.00
58.00	05800	MRI	104,337	47,739	0	17,643	0	58.00
60.00	06000	LABORATORY	1,103,708	207,603	0	76,726	0	60.00
65.00	06500	RESPIRATORY THERAPY	427,722	95,973	0	35,470	0	65.00
66.00	06600	PHYSICAL THERAPY	270,183	107,176	0	39,610	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	97,675	54,623	0	20,188	0	67.00
68.00	06800	SPEECH PATHOLOGY	50,277	18,628	0	6,884	0	68.00
69.00	06900	ELECTROCARDIOLOGY	311,954	245,578	0	90,761	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	67,772	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	33,042	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,233,582	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	27,011	18,133	0	6,701	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	398,210	338,491	0	125,100	0	90.00
90.01	09001	CLINIC - DIABETES	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	1,795,512	262,046	0	96,847	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	14,680,006	3,885,294	284,091	1,393,259	1,169,486	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	12,548	42,699	0	15,781	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	60,370	1,963,906	0	0	0	192.00
194.00	07950	OCCUPATIONAL HEALTH	12,025	116,175	0	42,936	0	194.00
194.02	07952	BLOOMNGTN AMBULANCE AND OCC MED	6,927	287,198	0	0	0	194.02
194.03	07953	HOME CARE	0	0	0	0	0	194.03
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)	14,771,876	6,295,272	284,091	1,451,976	1,169,486	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1328 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part I | Date/Time Prepared: 5/30/2023 10:36 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	SOCIAL SERVICE	
			11.00	13.00	14.00	15.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	446,335					11.00
13.00	01300	NURSING ADMINISTRATION	25,000	3,222,106				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,933	0	1,248,712			14.00
15.00	01500	PHARMACY	16,803	0	29,241	2,759,090		15.00
17.00	01700	SOCIAL SERVICE	1,460	0	0	0	101,829	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	82,710	1,308,689	110,631	7,485	80,051	30.00
31.00	03100	INTENSIVE CARE UNIT	33,372	486,791	58,033	5,393	21,778	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	24,104	137,317	244,616	5,537	0	50.00
51.00	05100	RECOVERY ROOM	8,664	148,342	243	58	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	28,524	0	43,006	3,353	0	54.00
56.00	05600	RADIOISOTOPE	2,220	0	1,385	221	0	56.00
57.00	05700	CT SCAN	12,500	1,336	8,295	101	0	57.00
58.00	05800	MRI	7,340	0	2,389	0	0	58.00
60.00	06000	LABORATORY	36,487	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	26,363	0	80,503	0	0	65.00
66.00	06600	PHYSICAL THERAPY	19,178	0	373	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	7,243	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	3,446	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	9,326	76,510	18,999	466	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	350,904	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	171,078	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	2,704,721	0	73.00
76.97	07697	CARDIAC REHABILITATION	1,791	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	27,278	295,683	16,779	7,062	0	90.00
90.01	09001	CLINIC - DIABETES	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	67,016	766,770	111,231	24,693	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	444,758	3,221,438	1,247,706	2,759,090	101,829	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,538	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	1,006	0	0	192.00
194.00	07950	OCCUPATIONAL HEALTH	0	0	0	0	0	194.00
194.02	07952	BLOOMNGTN AMBULANCE AND OCC MED	39	668	0	0	0	194.02
194.03	07953	HOME CARE	0	0	0	0	0	194.03
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)	446,335	3,222,106	1,248,712	2,759,090	101,829	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1328 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part I | Date/Time Prepared: 5/30/2023 10:36 am

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
17.00	01700	SOCIAL SERVICE					17.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	12,591,591	0	12,591,591		30.00
31.00	03100	INTENSIVE CARE UNIT	4,528,358	0	4,528,358		31.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	3,749,187	0	3,749,187		50.00
51.00	05100	RECOVERY ROOM	913,452	0	913,452		51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,026,180	0	3,026,180		54.00
56.00	05600	RADIOISOTOPE	244,676	0	244,676		56.00
57.00	05700	CT SCAN	830,883	0	830,883		57.00
58.00	05800	MRI	616,966	0	616,966		58.00
60.00	06000	LABORATORY	6,052,737	0	6,052,737		60.00
65.00	06500	RESPIRATORY THERAPY	2,459,611	0	2,459,611		65.00
66.00	06600	PHYSICAL THERAPY	1,569,486	0	1,569,486		66.00
67.00	06700	OCCUPATIONAL THERAPY	589,312	0	589,312		67.00
68.00	06800	SPEECH PATHOLOGY	290,063	0	290,063		68.00
69.00	06900	ELECTROCARDIOLOGY	2,061,718	0	2,061,718		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	702,866	0	702,866		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	342,674	0	342,674		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	19,497,873	0	19,497,873		73.00
76.97	07697	CARDIAC REHABILITATION	166,902	0	166,902		76.97
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	2,878,427	0	2,878,427		90.00
90.01	09001	CLINIC - DIABETES	0	0	0		90.01
91.00	09100	EMERGENCY	10,653,289	0	10,653,289		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0			92.00
		SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	73,766,251	0	73,766,251		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	125,184	0	125,184		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,278,434	0	2,278,434		192.00
194.00	07950	OCCUPATIONAL HEALTH	221,562	0	221,562		194.00
194.02	07952	BLOOMNGTN AMBULANCE AND OCC MED	323,879	0	323,879		194.02
194.03	07953	HOME CARE	0	0	0		194.03
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)	76,715,310	0	76,715,310		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1328 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part II Date/Time Prepared: 5/30/2023 10:36 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	2,232	7,046	9,278	9,278	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	109,976	347,208	457,184	245	5.00
7.00	00700	OPERATION OF PLANT	0	88,110	278,173	366,283	267	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	3,365	10,623	13,988	0	8.00
9.00	00900	HOUSEKEEPING	0	7,648	24,145	31,793	207	9.00
10.00	01000	DIETARY	0	18,081	57,084	75,165	126	10.00
11.00	01100	CAFETERIA	0	8,120	25,636	33,756	38	11.00
13.00	01300	NURSING ADMINISTRATION	0	26,296	83,018	109,314	565	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	18,540	58,534	77,074	30	14.00
15.00	01500	PHARMACY	0	6,335	19,999	26,334	318	15.00
17.00	01700	SOCIAL SERVICE	0	1,240	3,916	5,156	20	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	49,694	156,891	206,585	1,935	30.00
31.00	03100	INTENSIVE CARE UNIT	0	13,395	42,288	55,683	781	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	52,789	166,660	219,449	500	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	185	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	27,188	85,837	113,025	447	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	37	56.00
57.00	05700	CT SCAN	0	4,751	14,999	19,750	168	57.00
58.00	05800	MRI	0	4,554	14,376	18,930	100	58.00
60.00	06000	LABORATORY	0	19,802	62,518	82,320	117	60.00
65.00	06500	RESPIRATORY THERAPY	0	9,154	28,901	38,055	529	65.00
66.00	06600	PHYSICAL THERAPY	0	10,223	32,275	42,498	274	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	5,210	16,449	21,659	123	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,777	5,610	7,387	62	68.00
69.00	06900	ELECTROCARDIOLOGY	0	23,424	73,954	97,378	162	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	1,730	5,460	7,190	28	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	32,287	101,934	134,221	435	90.00
90.01	09001	CLINIC - DIABETES	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	24,995	78,913	103,908	1,568	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	570,916	1,802,447	2,373,363	9,267	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	4,073	12,859	16,932	11	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	187,326	0	187,326	0	192.00
194.00	07950	OCCUPATIONAL HEALTH	0	11,081	34,985	46,066	0	194.00
194.02	07952	BLOOMNGTN AMBULANCE AND OCC MED	0	27,394	0	27,394	0	194.02
194.03	07953	HOME CARE	0	0	0	0	0	194.03
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	800,790	1,850,291	2,651,081	9,278	202.00

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		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	457,429					5.00
7.00	00700	OPERATION OF PLANT	37,539	404,089				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,484	2,264	17,736			8.00
9.00	00900	HOUSEKEEPING	8,180	5,147	0	45,327		9.00
10.00	01000	DIETARY	5,426	12,168	0	2,187	95,072	10.00
11.00	01100	CAFETERIA	1,966	5,464	0	982	0	11.00
13.00	01300	NURSING ADMINISTRATION	16,813	17,696	0	3,181	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	5,835	12,477	0	2,243	0	14.00
15.00	01500	PHARMACY	15,635	4,263	0	766	0	15.00
17.00	01700	SOCIAL SERVICE	492	835	0	150	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	54,536	33,442	13,943	6,011	74,740	30.00
31.00	03100	INTENSIVE CARE UNIT	20,392	9,014	3,793	1,620	20,332	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	15,382	35,524	0	6,385	0	50.00
51.00	05100	RECOVERY ROOM	4,509	0	0	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	15,271	18,296	0	3,289	0	54.00
56.00	05600	RADIOISOTOPE	1,436	0	0	0	0	56.00
57.00	05700	CT SCAN	4,415	3,197	0	575	0	57.00
58.00	05800	MRI	3,231	3,064	0	551	0	58.00
60.00	06000	LABORATORY	34,179	13,326	0	2,395	0	60.00
65.00	06500	RESPIRATORY THERAPY	13,246	6,160	0	1,107	0	65.00
66.00	06600	PHYSICAL THERAPY	8,367	6,880	0	1,237	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,025	3,506	0	630	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,557	1,196	0	215	0	68.00
69.00	06900	ELECTROCARDIOLOGY	9,660	15,763	0	2,833	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,099	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,023	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	100,114	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	836	1,164	0	209	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	12,332	21,728	0	3,905	0	90.00
90.01	09001	CLINIC - DIABETES	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	55,603	16,821	0	3,023	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	454,583	249,395	17,736	43,494	95,072	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	389	2,741	0	493	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,870	126,061	0	0	0	192.00
194.00	07950	OCCUPATIONAL HEALTH	372	7,457	0	1,340	0	194.00
194.02	07952	BLOOMNGTN AMBULANCE AND OCC MED	215	18,435	0	0	0	194.02
194.03	07953	HOME CARE	0	0	0	0	0	194.03
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)	457,429	404,089	17,736	45,327	95,072	202.00

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		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	SOCIAL SERVICE	
			11.00	13.00	14.00	15.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	42,206					11.00
13.00	01300	NURSING ADMINISTRATION	2,364	149,933				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	372	0	98,031			14.00
15.00	01500	PHARMACY	1,589	0	2,296	51,201		15.00
17.00	01700	SOCIAL SERVICE	138	0	0	0	6,791	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,822	60,896	8,685	139	5,339	30.00
31.00	03100	INTENSIVE CARE UNIT	3,156	22,652	4,556	100	1,452	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,279	6,390	19,204	103	0	50.00
51.00	05100	RECOVERY ROOM	819	6,903	19	1	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,697	0	3,376	62	0	54.00
56.00	05600	RADIOISOTOPE	210	0	109	4	0	56.00
57.00	05700	CT SCAN	1,182	62	651	2	0	57.00
58.00	05800	MRI	694	0	188	0	0	58.00
60.00	06000	LABORATORY	3,450	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	2,493	0	6,320	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,814	0	29	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	685	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	326	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	882	3,560	1,492	9	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	27,547	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	13,431	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	50,192	0	73.00
76.97	07697	CARDIAC REHABILITATION	169	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,579	13,759	1,317	131	0	90.00
90.01	09001	CLINIC - DIABETES	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	6,337	35,680	8,732	458	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	42,057	149,902	97,952	51,201	6,791	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	145	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	79	0	0	192.00
194.00	07950	OCCUPATIONAL HEALTH	0	0	0	0	0	194.00
194.02	07952	BLOOMNGTN AMBULANCE AND OCC MED	4	31	0	0	0	194.02
194.03	07953	HOME CARE	0	0	0	0	0	194.03
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)	42,206	149,933	98,031	51,201	6,791	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1328 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part II Date/Time Prepared: 5/30/2023 10:36 am

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
17.00	01700	SOCIAL SERVICE					17.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	474,073	0	474,073		30.00
31.00	03100	INTENSIVE CARE UNIT	143,531	0	143,531		31.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	305,216	0	305,216		50.00
51.00	05100	RECOVERY ROOM	12,436	0	12,436		51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	156,463	0	156,463		54.00
56.00	05600	RADIOISOTOPE	1,796	0	1,796		56.00
57.00	05700	CT SCAN	30,002	0	30,002		57.00
58.00	05800	MRI	26,758	0	26,758		58.00
60.00	06000	LABORATORY	135,787	0	135,787		60.00
65.00	06500	RESPIRATORY THERAPY	67,910	0	67,910		65.00
66.00	06600	PHYSICAL THERAPY	61,099	0	61,099		66.00
67.00	06700	OCCUPATIONAL THERAPY	29,628	0	29,628		67.00
68.00	06800	SPEECH PATHOLOGY	10,743	0	10,743		68.00
69.00	06900	ELECTROCARDIOLOGY	131,739	0	131,739		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	29,646	0	29,646		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	14,454	0	14,454		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	150,306	0	150,306		73.00
76.97	07697	CARDIAC REHABILITATION	9,596	0	9,596		76.97
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	190,407	0	190,407		90.00
90.01	09001	CLINIC - DIABETES	0	0	0		90.01
91.00	09100	EMERGENCY	232,130	0	232,130		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0			92.00
		SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,213,720	0	2,213,720		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	20,711	0	20,711		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	315,336	0	315,336		192.00
194.00	07950	OCCUPATIONAL HEALTH	55,235	0	55,235		194.00
194.02	07952	BLOOMNGTN AMBULANCE AND OCC MED	46,079	0	46,079		194.02
194.03	07953	HOME CARE	0	0	0		194.03
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)	2,651,081	0	2,651,081		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1328 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B-1 | Date/Time Prepared: 5/30/2023 10:36 am

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	186,588					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		136,557				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	520	520	24,472,402			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	25,625	25,625	647,523	-14,771,876	61,943,434	5.00
7.00	00700	OPERATION OF PLANT	20,530	20,530	703,248	0	5,083,088	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	784	784	0	0	200,905	8.00
9.00	00900	HOUSEKEEPING	1,782	1,782	545,695	0	1,107,650	9.00
10.00	01000	DIETARY	4,213	4,213	331,381	0	734,668	10.00
11.00	01100	CAFETERIA	1,892	1,892	100,442	0	266,250	11.00
13.00	01300	NURSING ADMINISTRATION	6,127	6,127	1,490,290	0	2,276,625	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	4,320	4,320	79,406	0	790,139	14.00
15.00	01500	PHARMACY	1,476	1,476	839,014	0	2,117,195	15.00
17.00	01700	SOCIAL SERVICE	289	289	53,157	0	66,663	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,579	11,579	5,095,722	0	7,384,718	30.00
31.00	03100	INTENSIVE CARE UNIT	3,121	3,121	2,061,385	0	2,761,299	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	12,300	12,300	1,318,711	0	2,082,924	50.00
51.00	05100	RECOVERY ROOM	0	0	488,951	0	610,546	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,335	6,335	1,178,619	0	2,067,798	54.00
56.00	05600	RADIOISOTOPE	0	0	97,546	0	194,473	56.00
57.00	05700	CT SCAN	1,107	1,107	443,176	0	597,860	57.00
58.00	05800	MRI	1,061	1,061	263,563	0	437,518	58.00
60.00	06000	LABORATORY	4,614	4,614	309,630	0	4,628,213	60.00
65.00	06500	RESPIRATORY THERAPY	2,133	2,133	1,395,289	0	1,793,580	65.00
66.00	06600	PHYSICAL THERAPY	2,382	2,382	723,856	0	1,132,966	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,214	1,214	324,831	0	409,583	67.00
68.00	06800	SPEECH PATHOLOGY	414	414	164,336	0	210,828	68.00
69.00	06900	ELECTROCARDIOLOGY	5,458	5,458	426,755	0	1,308,124	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	284,190	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	138,554	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	13,559,570	73.00
76.97	07697	CARDIAC REHABILITATION	403	403	74,789	0	113,266	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	7,523	7,523	1,147,789	0	1,669,824	90.00
90.01	09001	CLINIC - DIABETES	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	5,824	5,824	4,137,325	0	7,529,174	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	133,026	133,026	24,442,429	-14,771,876	61,558,191	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	949	949	28,956	0	52,618	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	43,648	0	193	0	253,152	192.00
194.00	07950	OCCUPATIONAL HEALTH	2,582	2,582	0	0	50,426	194.00
194.02	07952	BLOOMNGTN AMBULANCE AND OCC MED	6,383	0	824	0	29,047	194.02
194.03	07953	HOME CARE	0	0	0	0	0	194.03
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)	800,790	1,850,291	3,844,058		14,771,876	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	4.291755	13.549587	0.157077		0.238474	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			9,278		457,429	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000379		0.007385	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: 15-1328 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B-1 | Date/Time Prepared: 5/30/2023 10:36 am

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (TOTAL PATI ENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (TOTAL PATI ENT DAYS)	CAFETERIA (FTE)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	139,913					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	784	7,617				8.00
9.00	00900	HOUSEKEEPING	1,782	0	87,316			9.00
10.00	01000	DIETARY	4,213	0	4,213	7,617		10.00
11.00	01100	CAFETERIA	1,892	0	1,892	0	22,924	11.00
13.00	01300	NURSING ADMINISTRATION	6,127	0	6,127	0	1,284	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	4,320	0	4,320	0	202	14.00
15.00	01500	PHARMACY	1,476	0	1,476	0	863	15.00
17.00	01700	SOCIAL SERVICE	289	0	289	0	75	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,579	5,988	11,579	5,988	4,248	30.00
31.00	03100	INTENSIVE CARE UNIT	3,121	1,629	3,121	1,629	1,714	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	12,300	0	12,300	0	1,238	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	445	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,335	0	6,335	0	1,465	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	114	56.00
57.00	05700	CT SCAN	1,107	0	1,107	0	642	57.00
58.00	05800	MRI	1,061	0	1,061	0	377	58.00
60.00	06000	LABORATORY	4,614	0	4,614	0	1,874	60.00
65.00	06500	RESPIRATORY THERAPY	2,133	0	2,133	0	1,354	65.00
66.00	06600	PHYSICAL THERAPY	2,382	0	2,382	0	985	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,214	0	1,214	0	372	67.00
68.00	06800	SPEECH PATHOLOGY	414	0	414	0	177	68.00
69.00	06900	ELECTROCARDIOLOGY	5,458	0	5,458	0	479	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	403	0	403	0	92	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	7,523	0	7,523	0	1,401	90.00
90.01	09001	CLINIC - DIABETES	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	5,824	0	5,824	0	3,442	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	86,351	7,617	83,785	7,617	22,843	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	949	0	949	0	79	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	43,648	0	0	0	0	192.00
194.00	07950	OCCUPATIONAL HEALTH	2,582	0	2,582	0	0	194.00
194.02	07952	BLOOMNGTN AMBULANCE AND OCC MED	6,383	0	0	0	2	194.02
194.03	07953	HOME CARE	0	0	0	0	0	194.03
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)	6,295,272	284,091	1,451,976	1,169,486	446,335	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	44.994189	37.296967	16.628980	153.536300	19.470206	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	404,089	17,736	45,327	95,072	42,206	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	2.888145	2.328476	0.519114	12.481554	1.841127	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: 15-1328 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B-1 | Date/Time Prepared: 5/30/2023 10:36 am

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NRSING HR)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	SOCIAL SERVICE (TOTAL PATI ENT DAYS)		
			13.00	14.00	15.00	17.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	9,644					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,011,308				14.00
15.00	01500	PHARMACY	0	23,682	13,832,136			15.00
17.00	01700	SOCIAL SERVICE	0	0	0	7,617		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,917	89,598	37,523	5,988		30.00
31.00	03100	INTENSIVE CARE UNIT	1,457	47,000	27,038	1,629		31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	411	198,110	27,757	0		50.00
51.00	05100	RECOVERY ROOM	444	197	292	0		51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	34,830	16,812	0		54.00
56.00	05600	RADIOISOTOPE	0	1,122	1,110	0		56.00
57.00	05700	CT SCAN	4	6,718	505	0		57.00
58.00	05800	MRI	0	1,935	0	0		58.00
60.00	06000	LABORATORY	0	0	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	65,198	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	302	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	229	15,387	2,335	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	284,188	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	138,553	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	13,559,570	0		73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	885	13,589	35,402	0		90.00
90.01	09001	CLINIC - DIABETES	0	0	0	0		90.01
91.00	09100	EMERGENCY	2,295	90,084	123,792	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	9,642	1,010,493	13,832,136	7,617		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	815	0	0		192.00
194.00	07950	OCCUPATIONAL HEALTH	0	0	0	0		194.00
194.02	07952	BLOOMNGTN AMBULANCE AND OCC MED	2	0	0	0		194.02
194.03	07953	HOME CARE	0	0	0	0		194.03
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)	3,222,106	1,248,712	2,759,090	101,829		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	334.104728	1.234749	0.199470	13.368649		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	149,933	98,031	51,201	6,791		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	15.546765	0.096935	0.003702	0.891558		205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1328 | Period: From 01/01/2022 To 12/31/2022 | Worksheet C Part I Date/Time Prepared: 5/30/2023 10:36 am

Title XVIII | 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	12,591,591		12,591,591	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	4,528,358		4,528,358	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,749,187		3,749,187	0	0	50.00
51.00	05100	RECOVERY ROOM	913,452		913,452	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,026,180		3,026,180	0	0	54.00
56.00	05600	RADIOISOTOPE	244,676		244,676	0	0	56.00
57.00	05700	CT SCAN	830,883		830,883	0	0	57.00
58.00	05800	MRI	616,966		616,966	0	0	58.00
60.00	06000	LABORATORY	6,052,737		6,052,737	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	2,459,611	0	2,459,611	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,569,486	0	1,569,486	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	589,312	0	589,312	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	290,063	0	290,063	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	2,061,718		2,061,718	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	702,866		702,866	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	342,674		342,674	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	19,497,873		19,497,873	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	166,902		166,902	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,878,427		2,878,427	0	0	90.00
90.01	09001	CLINIC - DIABETES	0		0	0	0	90.01
91.00	09100	EMERGENCY	10,653,289		10,653,289	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,383,296		2,383,296		0	92.00
200.00		Subtotal (see instructions)	76,149,547	0	76,149,547	0	0	200.00
201.00		Less Observation Beds	2,383,296		2,383,296		0	201.00
202.00		Total (see instructions)	73,766,251	0	73,766,251	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1328 | Period: From 01/01/2022 To 12/31/2022 | Worksheet C Part I Date/Time Prepared: 5/30/2023 10:36 am

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	15,723,547		15,723,547			30.00
31.00	03100	INTENSIVE CARE UNIT	11,735,678		11,735,678			31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,145,355	28,298,740	31,444,095	0.119233	0.000000	50.00
51.00	05100	RECOVERY ROOM	186,450	6,473,500	6,659,950	0.137156	0.000000	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,379,638	16,221,291	17,600,929	0.171933	0.000000	54.00
56.00	05600	RADIOISOTOPE	306,054	3,333,498	3,639,552	0.067227	0.000000	56.00
57.00	05700	CT SCAN	1,242,724	13,521,742	14,764,466	0.056276	0.000000	57.00
58.00	05800	MRI	351,103	3,302,335	3,653,438	0.168873	0.000000	58.00
60.00	06000	LABORATORY	6,186,993	23,888,955	30,075,948	0.201248	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	3,073,736	4,881,233	7,954,969	0.309192	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	609,691	3,057,105	3,666,796	0.428027	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	518,108	1,351,574	1,869,682	0.315194	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	198,717	438,346	637,063	0.455313	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	1,928,903	12,867,005	14,795,908	0.139344	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	569,205	1,809,495	2,378,700	0.295483	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	125,498	865,392	990,890	0.345824	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	10,877,312	78,197,254	89,074,566	0.218894	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	0	1,763,729	1,763,729	0.094630	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	52,145	17,357,372	17,409,517	0.165336	0.000000	90.00
90.01	09001	CLINIC - DIABETES	0	0	0	0.000000	0.000000	90.01
91.00	09100	EMERGENCY	2,181,630	53,750,829	55,932,459	0.190467	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	20,227	8,280,111	8,300,338	0.287132	0.000000	92.00
200.00		Subtotal (see instructions)	60,412,714	279,659,506	340,072,220			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	60,412,714	279,659,506	340,072,220			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1328 | Period: From 01/01/2022 To 12/31/2022 | Worksheet C Part I Date/Time Prepared: 5/30/2023 10:36 am

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio
			11.00
		INPATIENT ROUTINE SERVICE COST CENTERS	
30.00	03000	ADULTS & PEDIATRICS	
31.00	03100	INTENSIVE CARE UNIT	
		ANCILLARY SERVICE COST CENTERS	
50.00	05000	OPERATING ROOM	0.000000
51.00	05100	RECOVERY ROOM	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000
56.00	05600	RADIOISOTOPE	0.000000
57.00	05700	CT SCAN	0.000000
58.00	05800	MRI	0.000000
60.00	06000	LABORATORY	0.000000
65.00	06500	RESPIRATORY THERAPY	0.000000
66.00	06600	PHYSICAL THERAPY	0.000000
67.00	06700	OCCUPATIONAL THERAPY	0.000000
68.00	06800	SPEECH PATHOLOGY	0.000000
69.00	06900	ELECTROCARDIOLOGY	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000
76.97	07697	CARDIAC REHABILITATION	0.000000
		OUTPATIENT SERVICE COST CENTERS	
90.00	09000	CLINIC	0.000000
90.01	09001	CLINIC - DIABETES	0.000000
91.00	09100	EMERGENCY	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000
200.00		Subtotal (see instructions)	
201.00		Less Observation Beds	
202.00		Total (see instructions)	

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1328 | Period: From 01/01/2022 To 12/31/2022 | Worksheet C Part I Date/Time Prepared: 5/30/2023 10:36 am

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	12,591,591		12,591,591	0	12,591,591	30.00
31.00	03100	INTENSIVE CARE UNIT	4,528,358		4,528,358	0	4,528,358	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,749,187		3,749,187	0	3,749,187	50.00
51.00	05100	RECOVERY ROOM	913,452		913,452	0	913,452	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,026,180		3,026,180	0	3,026,180	54.00
56.00	05600	RADIOISOTOPE	244,676		244,676	0	244,676	56.00
57.00	05700	CT SCAN	830,883		830,883	0	830,883	57.00
58.00	05800	MRI	616,966		616,966	0	616,966	58.00
60.00	06000	LABORATORY	6,052,737		6,052,737	0	6,052,737	60.00
65.00	06500	RESPIRATORY THERAPY	2,459,611	0	2,459,611	0	2,459,611	65.00
66.00	06600	PHYSICAL THERAPY	1,569,486	0	1,569,486	0	1,569,486	66.00
67.00	06700	OCCUPATIONAL THERAPY	589,312	0	589,312	0	589,312	67.00
68.00	06800	SPEECH PATHOLOGY	290,063	0	290,063	0	290,063	68.00
69.00	06900	ELECTROCARDIOLOGY	2,061,718		2,061,718	0	2,061,718	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	702,866		702,866	0	702,866	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	342,674		342,674	0	342,674	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	19,497,873		19,497,873	0	19,497,873	73.00
76.97	07697	CARDIAC REHABILITATION	166,902		166,902	0	166,902	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,878,427		2,878,427	0	2,878,427	90.00
90.01	09001	CLINIC - DIABETES	0		0	0	0	90.01
91.00	09100	EMERGENCY	10,653,289		10,653,289	0	10,653,289	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,383,296		2,383,296		2,383,296	92.00
200.00		Subtotal (see instructions)	76,149,547	0	76,149,547	0	76,149,547	200.00
201.00		Less Observation Beds	2,383,296		2,383,296		2,383,296	201.00
202.00		Total (see instructions)	73,766,251	0	73,766,251	0	73,766,251	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1328 | Period: From 01/01/2022 To 12/31/2022 | Worksheet C Part I Date/Time Prepared: 5/30/2023 10:36 am

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	15,723,547		15,723,547			30.00
31.00	03100	INTENSIVE CARE UNIT	11,735,678		11,735,678			31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,145,355	28,298,740	31,444,095	0.119233	0.000000	50.00
51.00	05100	RECOVERY ROOM	186,450	6,473,500	6,659,950	0.137156	0.000000	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,379,638	16,221,291	17,600,929	0.171933	0.000000	54.00
56.00	05600	RADIOISOTOPE	306,054	3,333,498	3,639,552	0.067227	0.000000	56.00
57.00	05700	CT SCAN	1,242,724	13,521,742	14,764,466	0.056276	0.000000	57.00
58.00	05800	MRI	351,103	3,302,335	3,653,438	0.168873	0.000000	58.00
60.00	06000	LABORATORY	6,186,993	23,888,955	30,075,948	0.201248	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	3,073,736	4,881,233	7,954,969	0.309192	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	609,691	3,057,105	3,666,796	0.428027	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	518,108	1,351,574	1,869,682	0.315194	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	198,717	438,346	637,063	0.455313	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	1,928,903	12,867,005	14,795,908	0.139344	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	569,205	1,809,495	2,378,700	0.295483	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	125,498	865,392	990,890	0.345824	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	10,877,312	78,197,254	89,074,566	0.218894	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	0	1,763,729	1,763,729	0.094630	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	52,145	17,357,372	17,409,517	0.165336	0.000000	90.00
90.01	09001	CLINIC - DIABETES	0	0	0	0.000000	0.000000	90.01
91.00	09100	EMERGENCY	2,181,630	53,750,829	55,932,459	0.190467	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	20,227	8,280,111	8,300,338	0.287132	0.000000	92.00
200.00		Subtotal (see instructions)	60,412,714	279,659,506	340,072,220			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	60,412,714	279,659,506	340,072,220			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1328 | Period: From 01/01/2022 To 12/31/2022 | Worksheet C Part I Date/Time Prepared: 5/30/2023 10:36 am

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
51.00	05100	RECOVERY ROOM	0.000000		51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
56.00	05600	RADIOISOTOPE	0.000000		56.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MRI	0.000000		58.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.97	07697	CARDIAC REHABILITATION	0.000000		76.97
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	CLINIC - DIABETES	0.000000		90.01
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-1328 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part II Date/Time Prepared: 5/30/2023 10:36 am

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	305,216	31,444,095	0.009707	1,680,630	16,314	50.00
51.00	05100	RECOVERY ROOM	12,436	6,659,950	0.001867	113,519	212	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	156,463	17,600,929	0.008889	612,183	5,442	54.00
56.00	05600	RADIOISOTOPE	1,796	3,639,552	0.000493	123,830	61	56.00
57.00	05700	CT SCAN	30,002	14,764,466	0.002032	358,587	729	57.00
58.00	05800	MRI	26,758	3,653,438	0.007324	134,714	987	58.00
60.00	06000	LABORATORY	135,787	30,075,948	0.004515	2,614,313	11,804	60.00
65.00	06500	RESPIRATORY THERAPY	67,910	7,954,969	0.008537	1,072,203	9,153	65.00
66.00	06600	PHYSICAL THERAPY	61,099	3,666,796	0.016663	294,391	4,905	66.00
67.00	06700	OCCUPATIONAL THERAPY	29,628	1,869,682	0.015847	249,431	3,953	67.00
68.00	06800	SPEECH PATHOLOGY	10,743	637,063	0.016863	110,641	1,866	68.00
69.00	06900	ELECTROCARDIOLOGY	131,739	14,795,908	0.008904	966,883	8,609	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	29,646	2,378,700	0.012463	335,988	4,187	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	14,454	990,890	0.014587	125,498	1,831	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	150,306	89,074,566	0.001687	4,519,774	7,625	73.00
76.97	07697	CARDIAC REHABILITATION	9,596	1,763,729	0.005441	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	190,407	17,409,517	0.010937	43,453	475	90.00
90.01	09001	CLINIC - DIABETES	0	0	0.000000	0	0	90.01
91.00	09100	EMERGENCY	232,130	55,932,459	0.004150	181,317	752	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	89,731	8,300,338	0.010811	7,863	85	92.00
200.00		Total (lines 50 through 199)	1,685,847	312,612,995		13,545,218	78,990	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1328 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part IV | Date/Time Prepared: 5/30/2023 10:36 am

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC - DIABETES	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	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1328 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part IV Date/Time Prepared: 5/30/2023 10:36 am

Title XVIII | Hospital | Cost

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	31,444,095	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	6,659,950	0.000000	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	17,600,929	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	3,639,552	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	14,764,466	0.000000	57.00
58.00	05800	MRI	0	0	0	3,653,438	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	30,075,948	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	7,954,969	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	3,666,796	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,869,682	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	637,063	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	14,795,908	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	2,378,700	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	990,890	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	89,074,566	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	1,763,729	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	17,409,517	0.000000	90.00
90.01	09001	CLINIC - DIABETES	0	0	0	0	0.000000	90.01
91.00	09100	EMERGENCY	0	0	0	55,932,459	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	8,300,338	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	312,612,995		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1328 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part IV | Date/Time Prepared: 5/30/2023 10:36 am

Title XVIII | Hospital | Cost

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	1,680,630	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	113,519	0	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	612,183	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0.000000	123,830	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	358,587	0	0	0	57.00
58.00	05800	MRI	0.000000	134,714	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	2,614,313	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	1,072,203	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	294,391	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	249,431	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	110,641	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	966,883	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	335,988	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	125,498	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	4,519,774	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	43,453	0	0	0	90.00
90.01	09001	CLINIC - DIABETES	0.000000	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.000000	181,317	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	7,863	0	0	0	92.00
200.00		Total (lines 50 through 199)		13,545,218	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1328 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part V Date/Time Prepared: 5/30/2023 10:36 am

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.119233	0	5,136,444	0	0	50.00
51.00	05100	RECOVERY ROOM	0.137156	0	1,217,769	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.171933	0	3,333,544	0	0	54.00
56.00	05600	RADIOISOTOPE	0.067227	0	1,155,430	0	0	56.00
57.00	05700	CT SCAN	0.056276	0	4,029,359	0	0	57.00
58.00	05800	MRI	0.168873	0	800,249	0	0	58.00
60.00	06000	LABORATORY	0.201248	0	5,855,301	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.309192	0	1,367,250	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.428027	0	760,510	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.315194	0	354,847	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.455313	0	48,116	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.139344	0	3,171,239	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.295483	0	248,592	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.345824	0	262,526	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.218894	0	32,213,714	4,492	0	73.00
76.97	07697	CARDIAC REHABILITATION	0.094630	0	719,538	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.165336	0	6,262,448	2,353	0	90.00
90.01	09001	CLINIC - DIABETES	0.000000	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.190467	0	12,735,787	1,545	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.287132	0	1,959,804	2,390	0	92.00
200.00		Subtotal (see instructions)		0	81,632,467	10,780	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	81,632,467	10,780	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1328 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part V Date/Time Prepared: 5/30/2023 10:36 am

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	612,434	0		50.00
51.00	05100	RECOVERY ROOM	167,024	0		51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	573,146	0		54.00
56.00	05600	RADIOISOTOPE	77,676	0		56.00
57.00	05700	CT SCAN	226,756	0		57.00
58.00	05800	MRI	135,140	0		58.00
60.00	06000	LABORATORY	1,178,368	0		60.00
65.00	06500	RESPIRATORY THERAPY	422,743	0		65.00
66.00	06600	PHYSICAL THERAPY	325,519	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	111,846	0		67.00
68.00	06800	SPEECH PATHOLOGY	21,908	0		68.00
69.00	06900	ELECTROCARDIOLOGY	441,893	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	73,455	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	90,788	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,051,389	983		73.00
76.97	07697	CARDIAC REHABILITATION	68,090	0		76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	1,035,408	389		90.00
90.01	09001	CLINIC - DIABETES	0	0		90.01
91.00	09100	EMERGENCY	2,425,747	294		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	562,722	686		92.00
200.00		Subtotal (see instructions)	15,602,052	2,352		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	15,602,052	2,352		202.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-1328	Period: From 01/01/2022 To 12/31/2022	Worksheet D-1 Date/Time Prepared: 5/30/2023 10:36 am
	Title XVIII	Hospital	Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	7,386	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	7,386	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	5,988	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)	2,756	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	250.44	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	12,591,591	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)	12,591,591	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)	12,591,591	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)	1,704.79	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	4,698,401	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)	4,698,401	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1328 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-1 | Date/Time Prepared: 5/30/2023 10:36 am

Title XVIII | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	4,528,358	1,629	2,779.84	642	1,784,657	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	2,795,846	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)	9,278,904	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)	1,398	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,704.79	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	2,383,296	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1328 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-1 | Date/Time Prepared: 5/30/2023 10:36 am

Title XVIII | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	474,073	12,591,591	0.037650	2,383,296	89,731	90.00
91.00	Nursing Program cost	0	12,591,591	0.000000	2,383,296	0	91.00
92.00	Allied health cost	0	12,591,591	0.000000	2,383,296	0	92.00
93.00	All other Medical Education	0	12,591,591	0.000000	2,383,296	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-1328 Component CCN:	Period: From 01/01/2022 To 12/31/2022	Worksheet D-1 Date/Time Prepared: 5/30/2023 10:36 am
	Title XIX	Subprovider (Other)	

	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)	0	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	0	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)	0	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)	0	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	250.44	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	0	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)	0	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)	0	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)	0.00	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	0	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)	0	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-1328 | Component CCN: | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-1 | Date/Time Prepared: 5/30/2023 10:36 am

Title XIX | Subprovider (Other)

	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)						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)	0	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)	0	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
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-1328 Component CCN:	Period: From 01/01/2022 To 12/31/2022	Worksheet D-1 Date/Time Prepared: 5/30/2023 10:36 am
	Title XIX	Subprovider (Other)	

	Cost Center Description		
		1.00	
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	0	0	0.000000	0	0	90.00
91.00	Nursing Program cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1328 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-3 | Date/Time Prepared: 5/30/2023 10:36 am

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		7,246,976		30.00
31.00	03100	INTENSIVE CARE UNIT		4,868,161		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.119233	1,680,630	200,387	50.00
51.00	05100	RECOVERY ROOM	0.137156	113,519	15,570	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.171933	612,183	105,254	54.00
56.00	05600	RADIOISOTOPE	0.067227	123,830	8,325	56.00
57.00	05700	CT SCAN	0.056276	358,587	20,180	57.00
58.00	05800	MRI	0.168873	134,714	22,750	58.00
60.00	06000	LABORATORY	0.201248	2,614,313	526,125	60.00
65.00	06500	RESPIRATORY THERAPY	0.309192	1,072,203	331,517	65.00
66.00	06600	PHYSICAL THERAPY	0.428027	294,391	126,007	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.315194	249,431	78,619	67.00
68.00	06800	SPEECH PATHOLOGY	0.455313	110,641	50,376	68.00
69.00	06900	ELECTROCARDIOLOGY	0.139344	966,883	134,729	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.295483	335,988	99,279	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.345824	125,498	43,400	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.218894	4,519,774	989,351	73.00
76.97	07697	CARDIAC REHABILITATION	0.094630	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.165336	43,453	7,184	90.00
90.01	09001	CLINIC - DIABETES	0.000000	0	0	90.01
91.00	09100	EMERGENCY	0.190467	181,317	34,535	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.287132	7,863	2,258	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		13,545,218	2,795,846	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)		13,545,218		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-1328 | Component CCN: 15-Z328 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-3 | Date/Time Prepared: 5/30/2023 10:36 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.119233	0	0	50.00
51.00	05100	RECOVERY ROOM	0.137156	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.171933	0	0	54.00
56.00	05600	RADIOISOTOPE	0.067227	0	0	56.00
57.00	05700	CT SCAN	0.056276	0	0	57.00
58.00	05800	MRI	0.168873	0	0	58.00
60.00	06000	LABORATORY	0.201248	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.309192	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.428027	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.315194	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.455313	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.139344	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.295483	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.345824	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.218894	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0.094630	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.165336	0	0	90.00
90.01	09001	CLINIC - DIABETES	0.000000	0	0	90.01
91.00	09100	EMERGENCY	0.190467	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.287132	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		0	0	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)		0		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1328 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-3 | Date/Time Prepared: 5/30/2023 10:36 am

Title XIX | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		473,593		30.00
31.00	03100	INTENSIVE CARE UNIT		522,319		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.119233	39,023	4,653	50.00
51.00	05100	RECOVERY ROOM	0.137156	2,200	302	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.171933	42,296	7,272	54.00
56.00	05600	RADIOISOTOPE	0.067227	18,150	1,220	56.00
57.00	05700	CT SCAN	0.056276	65,022	3,659	57.00
58.00	05800	MRI	0.168873	12,147	2,051	58.00
60.00	06000	LABORATORY	0.201248	302,333	60,844	60.00
65.00	06500	RESPIRATORY THERAPY	0.309192	249,333	77,092	65.00
66.00	06600	PHYSICAL THERAPY	0.428027	13,126	5,618	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.315194	10,056	3,170	67.00
68.00	06800	SPEECH PATHOLOGY	0.455313	8,886	4,046	68.00
69.00	06900	ELECTROCARDIOLOGY	0.139344	36,059	5,025	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.295483	8,486	2,507	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.345824	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.218894	455,097	99,618	73.00
76.97	07697	CARDIAC REHABILITATION	0.094630	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.165336	0	0	90.00
90.01	09001	CLINIC - DIABETES	0.000000	0	0	90.01
91.00	09100	EMERGENCY	0.190467	197,095	37,540	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.287132	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,459,309	314,617	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)		1,459,309		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-1328 | Component CCN: 15-Z328 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-3 | Date/Time Prepared: 5/30/2023 10:36 am

Title XIX | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.119233	0	0	50.00
51.00	05100	RECOVERY ROOM	0.137156	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.171933	0	0	54.00
56.00	05600	RADIOISOTOPE	0.067227	0	0	56.00
57.00	05700	CT SCAN	0.056276	0	0	57.00
58.00	05800	MRI	0.168873	0	0	58.00
60.00	06000	LABORATORY	0.201248	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.309192	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.428027	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.315194	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.455313	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.139344	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.295483	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.345824	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.218894	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0.094630	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.165336	0	0	90.00
90.01	09001	CLINIC - DIABETES	0.000000	0	0	90.01
91.00	09100	EMERGENCY	0.190467	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.287132	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		0	0	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)		0		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1328	Period: From 01/01/2022 To 12/31/2022	Worksheet E Part B Date/Time Prepared: 5/30/2023 10:36 am
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	15,604,404	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	OPPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	15,604,404	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	15,760,448	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	116,407	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	14,263,024	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)	1,381,017	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)	1,381,017	30.00
31.00	Primary payer payments	1,033	31.00
32.00	Subtotal (line 30 minus line 31)	1,379,984	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)	1,383,344	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	899,174	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	322,366	36.00
37.00	Subtotal (see instructions)	2,279,158	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.75	N95 respirator payment adjustment amount (see instructions)	0	39.75
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	2,279,158	40.00
40.01	Sequestration adjustment (see instructions)	28,717	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	3,166,950	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)	-916,509	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	981,555	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: 15-1328	Period: From 01/01/2022 To 12/31/2022	Worksheet E Part B Date/Time Prepared: 5/30/2023 10:36 am
	Title XVIII	Hospital	Cost

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Provider CCN: 15-1328 | Period: From 01/01/2022 To 12/31/2022 | Worksheet E-1 Part I Date/Time Prepared: 5/30/2023 10:36 am

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		8,220,226		3,166,950	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		8,220,226		3,166,950	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		240,489		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		916,509	6.02
7.00	Total Medicare program liability (see instructions)		8,460,715		2,250,441	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: 15-1328 | Component CCN: 15-Z328 | Period: From 01/01/2022 To 12/31/2022 | Worksheet E-1 Part I | Date/Time Prepared: 5/30/2023 10:36 am

Title XVIII | Swing Beds - SNF | Cost

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

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-1328	Period: From 01/01/2022 To 12/31/2022	Worksheet E-1 Part II Date/Time Prepared: 5/30/2023 10:36 am
	Title XVIII	Hospital	Cost

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

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS | Provider CCN: 15-1328 | Component CCN: 15-Z328 | Period: From 01/01/2022 To 12/31/2022 | Worksheet E-2 | Date/Time Prepared: 5/30/2023 10:36 am

Title XVIII | Swing Beds - SNF | Cost

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

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS | Provider CCN: 15-1328 | Component CCN: 15-Z328 | Period: From 01/01/2022 To 12/31/2022 | Worksheet E-2 | Date/Time Prepared: 5/30/2023 10:36 am

Title XIX | Swing Beds - SNF | Cost

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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1328	Period: From 01/01/2022 To 12/31/2022	Worksheet E-3 Part V Date/Time Prepared: 5/30/2023 10:36 am
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	9,278,904	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)	0	2.00
3.00	Organ acquisition	0	3.00
3.01	Cellular therapy acquisition cost (see instructions)	0	3.01
4.00	Subtotal (sum of lines 1 through 3.01)	9,278,904	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	9,371,693	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	9,371,693	19.00
20.00	Deductibles (exclude professional component)	849,072	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	8,522,621	22.00
23.00	Coinsurance	7,780	23.00
24.00	Subtotal (line 22 minus line 23)	8,514,841	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	82,830	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	53,840	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	32,297	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	8,568,681	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29.98	Recovery of accelerated depreciation.	0	29.98
29.99	Demonstration payment adjustment amount before sequestration	0	29.99
30.00	Subtotal (see instructions)	8,568,681	30.00
30.01	Sequestration adjustment (see instructions)	107,966	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
30.03	Sequestration adjustment-PARHM or CHART		30.03
31.00	Interim payments	8,220,226	31.00
31.01	Interim payments-PARHM or CHART		31.01
32.00	Tentative settlement (for contractor use only)	0	32.00
32.01	Tentative settlement-PARHM or CHART (for contractor use only)		32.01
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)	240,489	33.00
33.01	Balance due provider/program-PARHM or CHART (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01)		33.01
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	565,416	34.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 15-1328 | Period: From 01/01/2022 To 12/31/2022 | Worksheet G | Date/Time Prepared: 5/30/2023 10:36 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	114,946,952	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	8,808,089	0	0	0	4.00
5.00	Other receivable	828,467	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	2,230,697	0	0	0	7.00
8.00	Prepaid expenses	227,977	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)	127,042,182	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	1,034,321	0	0	0	12.00
13.00	Land improvements	1,093,347	0	0	0	13.00
14.00	Accumulated depreciation	-1,071,121	0	0	0	14.00
15.00	Buildings	20,118,613	0	0	0	15.00
16.00	Accumulated depreciation	-13,833,566	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	205,251	0	0	0	21.00
22.00	Accumulated depreciation	-196,597	0	0	0	22.00
23.00	Major movable equipment	19,183,439	0	0	0	23.00
24.00	Accumulated depreciation	-13,280,976	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)	13,252,711	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	8,469,412	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	8,469,412	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	148,764,305	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	9,045,622	0	0	0	37.00
38.00	Salaries, wages, and fees payable	109,122	0	0	0	38.00
39.00	Payroll taxes payable	1,190,456	0	0	0	39.00
40.00	Notes and loans payable (short term)	62,370	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	5,216,824	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	15,624,394	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	178,307	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	178,307	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	15,802,701	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	132,961,604				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)	132,961,604	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	148,764,305	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-1328 | Period: From 01/01/2022 To 12/31/2022 | Worksheet G-1 | Date/Time Prepared: 5/30/2023 10:36 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		118,026,706		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		14,934,899				2.00
3.00	Total (sum of line 1 and line 2)		132,961,605		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00	ROUNDING	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)		132,961,605		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00	ROUDNING	1		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)		1		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		132,961,604		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	ROUNDING		0			5.00
6.00			0			6.00
7.00			0			7.00
8.00			0			8.00
9.00			0			9.00
10.00	Total additions (sum of line 4-9)	0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0		11.00
12.00	Deductions (debit adjustments) (specify)		0			12.00
13.00	ROUDNING		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: 15-1328 | Period: From 01/01/2022 To 12/31/2022 | Worksheet G-2 Parts I & II | Date/Time Prepared: 5/30/2023 10:36 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	15,653,115		15,653,115	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	70,432		70,432	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)	15,723,547		15,723,547	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	11,735,678		11,735,678	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)	11,735,678		11,735,678	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	27,459,225		27,459,225	17.00
18.00	Ancillary services	30,699,488	200,271,194	230,970,682	18.00
19.00	Outpatient services	2,254,002	79,388,312	81,642,314	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PHYSICIAN REVENUE	0	1,977,334	1,977,334	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	60,412,715	281,636,840	342,049,555	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		80,155,604		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)		80,155,604		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-1328 | Period: From 01/01/2022 To 12/31/2022 | Worksheet G-3 | Date/Time Prepared: 5/30/2023 10:36 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	342,049,555	1.00
2.00	Less contractual allowances and discounts on patients' accounts	248,675,023	2.00
3.00	Net patient revenues (line 1 minus line 2)	93,374,532	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	80,155,604	4.00
5.00	Net income from service to patients (line 3 minus line 4)	13,218,928	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISCELLANEOUS INCOME	1,715,971	24.00
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	1,715,971	25.00
26.00	Total (line 5 plus line 25)	14,934,899	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)	14,934,899	29.00