

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: 15-1316	Period: From 01/01/2022 To 12/31/2022	Worksheet S Parts I-III Date/Time Prepared: 5/26/2023 10:18 am
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PART I - COST REPORT STATUS

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

Date: 5/26/2023 Time: 10:18 am

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

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

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by IU HEALTH FRANKFORT HOSPITAL (15-1316) 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	Todd Williams	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	Todd Williams		2
3	Signatory Title	CHIEF FINANCIAL OFFICER		3
4	Date	(Dated when report is electronic)		4

	Title V	Title XVIII		HIT	Title XIX	
		Part A	Part B			
	1.00	2.00	3.00	4.00	5.00	
PART III - SETTLEMENT SUMMARY						
1.00	HOSPITAL	0	341,785	-811,753	0	0 1.00
2.00	SUBPROVIDER - IPF	0	0	0	0	0 2.00
3.00	SUBPROVIDER - IRF	0	0	0	0	0 3.00
5.00	SWING BED - SNF	0	52,779	0	0	0 5.00
6.00	SWING BED - NF	0	0	0	0	0 6.00
9.00	HOME HEALTH AGENCY I	0	0	0	0	0 9.00
200.00	TOTAL	0	394,564	-811,753	0	0 200.00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The number for this information collection is OMB 0938-0050 and the number for the Supplement to Form CMS 2552-10, Worksheet N95, is OMB 0938-1425. The time required to complete and review the information collection is estimated 675 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-1316		Period: From 01/01/2022 To 12/31/2022		Worksheet S-2 Part I Date/Time Prepared: 5/26/2023 10:18 am					
1.00		2.00		3.00		4.00					
Hospital and Hospital Health Care Complex Address:											
1.00	Street: 1300 SOUTH JACKSON STREET		PO Box:						1.00		
2.00	City: FRANKFORT		State: IN		Zip Code: 46041		County: CLINTON		2.00		
		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)				
		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		IU HEALTH FRANKFORT HOSPITAL	151316	99915	1	01/21/2003	N	0	0	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 FRANKFORT HOSPITAL	15Z316	99915		01/21/2003	N	0	N	7.00
8.00	Swing Beds - NF										8.00
9.00	Hospital-Based SNF										9.00
10.00	Hospital-Based NF										10.00
11.00	Hospital-Based OLTC										11.00
12.00	Hospital-Based HHA										12.00
13.00	Separately Certified ASC										13.00
14.00	Hospital-Based Hospice										14.00
15.00	Hospital-Based Health Clinic - RHC										15.00
16.00	Hospital-Based Health Clinic - FQHC										16.00
17.00	Hospital-Based (CMHC) I										17.00
18.00	Renal Dialysis										18.00
19.00	Other										19.00
						From:	To:				
						1.00	2.00				
20.00	Cost Reporting Period (mm/dd/yyyy)					01/01/2022	12/31/2022		20.00		
21.00	Type of Control (see instructions)					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	N			22.00		
22.01	Did this hospital receive interim UCPs, including supplemental UCPs, for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)				N	N			22.01		
22.02	Is this a newly merged hospital that requires a final UCP to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.				N	N			22.02		
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)				N	N	N		22.03		
22.04	Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.									22.04	
23.00	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)									23.00	
23.00	Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.									23.00	
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: 15-1316			Period: From 01/01/2022 To 12/31/2022		Worksheet S-2 Part I Date/Time Prepared: 5/26/2023 10:18 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	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.					0		36.00				
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					0		37.00				
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)							37.01				
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.							38.00				
						Y/N		Y/N				
						1.00		2.00				
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					N		N		39.00		
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					N		N		40.00		
						V		XVII		XIX		
						1.00		2.00		3.00		
Prospective Payment System (PPS)-Capital												
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section 412.320? (see instructions)					N		N		N		45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR 412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					N		N		N		46.00
47.00	Is this a new hospital under 42 CFR 412.300(b) PPS capital? Enter "Y" for yes or "N" for no.					N		N		N		47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N		N		N		48.00
Teaching Hospitals												
56.00	Is this a hospital involved in training residents in approved GME programs? For cost reporting periods beginning prior to December 27, 2020, enter "Y" for yes or "N" for no in column 1. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.78(b)(2), see the instructions. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2.					N						56.00
57.00	For cost reporting periods beginning prior to December 27, 2020, if line 56, column 1, is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.77(e)(1)(iv) and (v), regardless of which month(s) of the cost report the residents were on duty, if the response to line 56 is "Y" for yes, enter "Y" for yes in column 1, do not complete column 2, and complete Worksheet E-4.											57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.					N						58.00

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		V	XVIII	XIX			
		1.00	2.00	3.00			
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N					59.00
		NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code			
		1.00	2.00	3.00			
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.	N					60.00
		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).						61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06
		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count		
		1.00	2.00	3.00	4.00		
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0.00	0.00		61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0.00	0.00		61.20
						1.00	
62.00	ACA Provisions Affecting the Health Resources and Services Administration (HRSA) Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)					0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)					0.00	62.01
63.00	Teaching Hospitals that Claim Residents in Nonprovider Settings Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)					N	63.00

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

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			1.00		
68.00	Direct GME in Accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022) For a cost reporting period beginning prior to October 1, 2022, did you obtain permission from your MAC to apply the new DGME formula in accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022)?		N		68.00
			1.00	2.00	3.00
Inpatient Psychiatric Facility PPS					
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.		N		70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)		0		71.00
Inpatient Rehabilitation Facility PPS					
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.		N		75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)		0		76.00
			1.00		
Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.		N		80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.		N		81.00
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.		N		85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.		N		86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.		N		87.00
			Approved for Permanent Adjustment (Y/N)	Number of Approved Permanent Adjustments	
			1.00	2.00	
88.00	Column 1: Is this hospital approved for a permanent adjustment to the TEFRA target amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete col. 2 and line 89. (see instructions) Column 2: Enter the number of approved permanent adjustments.				0 88.00
			Wkst. A Line No.	Effective Date	Approved Permanent Adjustment Amount Per Discharge
			1.00	2.00	3.00
89.00	Column 1: If line 88, column 1 is Y, enter the Worksheet A line number on which the per discharge permanent adjustment approval was based. Column 2: Enter the effective date (i.e., the cost reporting period beginning date) for the permanent adjustment to the TEFRA target amount per discharge. Column 3: Enter the amount of the approved permanent adjustment to the TEFRA target amount per discharge.		0.00		0 89.00
			V	XIX	
			1.00	2.00	
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.		N		Y 90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.		N		N 91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N		N 92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.		N		N 93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.		N		N 94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.		0.00		0.00 95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.		N		N 96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.		0.00		0.00 97.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-1316	Period: From 01/01/2022 To 12/31/2022	Worksheet S-2 Part I Date/Time Prepared: 5/26/2023 10:18 am	
		V 1.00	XIX 2.00		
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. 1, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.00	
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. 1? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.01	
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. 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. 1, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.05	
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. 1 through 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 1.00	Occupational 2.00	Speech 3.00	Respiratory 4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	Y	Y	N	N
					1.00
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.				N
					1.00
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.			N	
					1.00
112.00	Did this hospital participate in the Pennsylvania Rural Health Model (PARHM) demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N			
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.				
Miscellaneous Cost Reporting Information					
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub. 15-1, chapter 22, §2208.1.	N			0115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.		2		118.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-1316	Period: From 01/01/2022 To 12/31/2022	Worksheet S-2 Part I Date/Time Prepared: 5/26/2023 10:18 am
		Premiums	Losses	Insurance
		1.00	2.00	3.00
118.01	List amounts of malpractice premiums and paid losses:	20,684	0	0
		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.		N	118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.		N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.		Y	121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.		Y	122.00
123.00	Did the facility and/or its subproviders (if applicable) purchase professional services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, and/or management/consulting services, from an unrelated organization? In column 1, enter "Y" for yes or "N" for no. If column 1 is "Y", were the majority of the expenses, i.e., greater than 50% of total professional services expenses, for services purchased from unrelated organizations located in a CBSA outside of the main hospital CBSA? In column 2, enter "Y" for yes or "N" for no.			123.00
Certified Transplant Center Information				
125.00	Does this facility operate a Medicare-certified transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.		N	125.00
126.00	If this is a Medicare-certified kidney transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare-certified heart transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare-certified liver transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare-certified lung transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare-certified pancreas transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare-certified intestinal transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare-certified islet transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is a hospital-based organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
All Providers				
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)		Y	140.00
		1.00	2.00	3.00
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.				
141.00	Name: INDIANA UNIVERSITY HEALTH	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: 15-1316		Period: From 01/01/2022 To 12/31/2022		Worksheet S-2 Part I Date/Time Prepared: 5/26/2023 10:18 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	N	155.00	
156.00	Subprovider - IPF	N	N	N	N	N	156.00	
157.00	Subprovider - IRF	N	N	N	N	N	157.00	
158.00	SUBPROVIDER						158.00	
159.00	SNF	N	N	N	N	N	159.00	
160.00	HOME HEALTH AGENCY	N	N	N	N	N	160.00	
161.00	CMHC		N	N	N	N	161.00	
1.00								
Multi campus								
165.00	Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.						N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00	166.00
1.00								
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act								
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.						Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)							168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)							168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)						0.00	169.00
		Beginning	Ending					
		1.00	2.00					
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)							170.00
		1.00	2.00					
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. 1, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)						84	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-1316		Period: From 01/01/2022 To 12/31/2022		Worksheet S-2 Part II Date/Time Prepared: 5/26/2023 10:18 am	
		Y/N	Date				
		1.00	2.00				
PART II - HOSPITAL AND HOSPITAL HEALTHCARE COMPLEX REIMBURSEMENT QUESTIONNAIRE							
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.							
COMPLETED BY ALL HOSPITALS							
Provider Organization and Operation							
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N					1.00
		Y/N	Date				
		1.00	2.00				
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N					2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y					3.00
		Y/N	Type				
		1.00	2.00				
Financial Data and Reports							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A				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					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: 15-1316	Period: From 01/01/2022 To 12/31/2022	Worksheet S-2 Part II Date/Time Prepared: 5/26/2023 10:18 am	
		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N	N		21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions		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.				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: 15-1316

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

Worksheet S-2
Part II
Date/Time Prepared:
5/26/2023 10:18 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.	GOVERNMENT PROGRAMS 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: 15-1316

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

Worksheet S-3
Part I
Date/Time Prepared:
5/26/2023 10:18 am

Component	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P		
	Line No.				Visits / Trips	Title V	
	1.00	2.00	3.00	4.00	5.00		
PART I - STATISTICAL DATA							
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	12	4,380	30,504.00	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)		12	4,380	30,504.00	0	7.00	
8.00 INTENSIVE CARE UNIT						8.00	
9.00 CORONARY CARE UNIT						9.00	
10.00 BURN INTENSIVE CARE UNIT						10.00	
11.00 SURGICAL INTENSIVE CARE UNIT						11.00	
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00	
13.00 NURSERY						13.00	
14.00 Total (see instructions)		12	4,380	30,504.00	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	101.00				0	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)		12				27.00	
28.00 Observation Bed Days					0	28.00	
29.00 Ambulance Trips						29.00	
30.00 Employee discount days (see instruction)						30.00	
31.00 Employee discount days - IRF						31.00	
32.00 Labor & delivery days (see instructions)		0	0			32.00	
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01	
33.00 LTCH non-covered days						33.00	
33.01 LTCH site neutral days and discharges						33.01	
34.00 Temporary Expansion COVID-19 PHE Acute Care	30.00	0	0		0	34.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 15-1316

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

Worksheet S-3
Part I
Date/Time Prepared:
5/26/2023 10:18 am

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVII I	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	520	19	1,271		1.00
2.00	HMO and other (see instructions)	416	120			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	137	0	137		5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	130		6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	657	19	1,538		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)	657	19	1,538	0.00	100.75
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	0	0	0	0.00	0.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)					23.00
24.00	HOSPICE					24.00
24.10	HOSPICE (non-distinct part)			73		24.10
25.00	CMHC - CMHC					25.00
26.00	RURAL HEALTH CLINIC					26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER					26.25
27.00	Total (sum of lines 14-26)	0	0	0	0.00	0.00
28.00	Observation Bed Days		17	449		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: 15-1316

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

Worksheet S-3
Part I
Date/Time Prepared:
5/26/2023 10:18 am

Component	Full Time Equivalents	Discharges			Total All Patients		
		Nonpaid Workers	Title V	Title XVIII			Title XIX
		11.00	12.00	13.00			14.00
PART I - STATISTICAL DATA							
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	172	4	416	1.00
2.00	HMO and other (see instructions)			128	41		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	172	4	416	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	0.00					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: 15-1316	Period: From 01/01/2022 To 12/31/2022	Worksheet S-10 Date/Time Prepared: 5/26/2023 10:18 am
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			1.00		
Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.378330	1.00	
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		2,690,873	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		17,807,968	6.00	
7.00	Medicaid cost (line 1 times line 6)		6,737,289	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)		4,046,416	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)		8,633	13.00	
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		64,279	14.00	
15.00	State or local indigent care program cost (line 1 times line 14)		24,319	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)		15,686	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)		4,062,102	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)	1,965,552	74,394	2,039,946	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	743,627	74,394	818,021	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)	743,627	74,394	818,021	23.00
			1.00		
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		N	24.00	
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit		0	25.00	
26.00	Total bad debt expense for the entire hospital complex (see instructions)		1,658,172	26.00	
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		206,342	27.00	
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		317,450	27.01	
28.00	Non-Medicare bad debt expense (see instructions)		1,340,722	28.00	
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		618,343	29.00	
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		1,436,364	30.00	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		5,498,466	31.00	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-1316

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

Worksheet A
Date/Time Prepared:
5/26/2023 10:18 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	3,509,038	3,509,038	1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	42,476	1,305,757	1,348,233	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	271,385	8,430,002	8,701,387	6,393,705	5.00
7.00	00700	OPERATION OF PLANT	502,495	2,038,929	2,541,424	1,621,178	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	55,364	55,364	8.00
9.00	00900	HOUSEKEEPING	287,948	377,176	665,124	543,704	9.00
10.00	01000	DIETARY	221,104	221,988	443,092	223,185	10.00
11.00	01100	CAFETERIA	0	0	164,857	164,857	11.00
13.00	01300	NURSING ADMINISTRATION	1,248,145	296,068	1,544,213	1,187,638	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	123,575	123,575	244,138	14.00
15.00	01500	PHARMACY	292,382	1,338,256	1,630,638	603,349	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,163,830	1,219,667	2,383,497	2,213,111	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	314,494	796,392	1,110,886	711,697	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	922,112	586,734	1,508,846	1,169,986	54.00
60.00	06000	LABORATORY	0	2,004,677	2,004,677	1,995,210	60.00
66.00	06600	PHYSICAL THERAPY	0	657,996	657,996	643,086	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	206,708	206,708	206,708	67.00
68.00	06800	SPEECH PATHOLOGY	97,124	18,272	115,396	104,457	68.00
69.00	06900	ELECTROCARDIOLOGY	32,688	83,476	116,164	76,778	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	47,896	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	47,580	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	494,143	73.00
73.01	07301	ONCOLOGY DRUGS	0	0	0	601,887	73.01
76.00	03160	CARDIOPULMONARY	742,371	414,476	1,156,847	1,098,388	76.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	77.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	1,313,053	2,136,400	3,449,453	3,097,083	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	7,409,131	20,993,268	28,402,399	28,402,399	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
192.02	19202	MOB	0	0	0	0	192.02
193.00	19300	NONPAID WORKERS	0	0	0	0	193.00
194.00	07950	LEASED SPACE	0	0	0	0	194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	7,409,131	20,993,268	28,402,399	28,402,399	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-1316

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

Worksheet A
Date/Time Prepared:
5/26/2023 10:18 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	-462,248	3,046,790	1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-185,672	1,162,561	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-366,561	6,027,144	5.00
7.00	00700	OPERATION OF PLANT	48,007	1,669,185	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	55,364	8.00
9.00	00900	HOUSEKEEPING	0	543,704	9.00
10.00	01000	DIETARY	0	223,185	10.00
11.00	01100	CAFETERIA	0	164,857	11.00
13.00	01300	NURSING ADMINISTRATION	174,028	1,361,666	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	143,810	387,948	14.00
15.00	01500	PHARMACY	225,268	828,617	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-246,888	1,966,223	30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-44,417	667,280	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	121,731	1,291,717	54.00
60.00	06000	LABORATORY	0	1,995,210	60.00
66.00	06600	PHYSICAL THERAPY	0	643,086	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	206,708	67.00
68.00	06800	SPEECH PATHOLOGY	0	104,457	68.00
69.00	06900	ELECTROCARDIOLOGY	0	76,778	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	47,896	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	47,580	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	494,143	73.00
73.01	07301	ONCOLOGY DRUGS	0	601,887	73.01
76.00	03160	CARDIOPULMONARY	18,200	1,116,588	76.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	77.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	-7,026	3,090,057	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	0	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	102.00
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-581,768	27,820,631	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
191.00	19100	RESEARCH	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
192.02	19202	MOB	0	0	192.02
193.00	19300	NONPAID WORKERS	0	0	193.00
194.00	07950	LEASED SPACE	0	0	194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-581,768	27,820,631	200.00

RECLASSIFICATIONS

Provider CCN: 15-1316

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

Worksheet A-6

Date/Time Prepared:
5/26/2023 10:18 am

		Increases				
Cost Center		Line #	Salary	Other		
2.00		3.00	4.00	5.00		
A - CAFETERIA						
1.00	CAFETERIA	11.00	92,908	71,949	1.00	
	0		92,908	71,949		
B - DRUGS						
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	494,143	1.00	
2.00	ONCOLOGY DRUGS	73.01	0	601,887	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	
	0		0	1,096,030		
C - MEDICAL SUPPLIES						
1.00	CENTRAL SERVICES & SUPPLY	14.00		127,923	1.00	
2.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00		47,896	2.00	
3.00	IMPL. DEV. CHARGED TO PATIENTS	72.00		47,580	3.00	
4.00	ADMINISTRATIVE & GENERAL	5.00		12,982	4.00	
5.00	HOUSEKEEPING	9.00		700	5.00	
6.00	DIETARY	10.00		7	6.00	
7.00	NURSING ADMINISTRATION	13.00		32	7.00	
8.00	RADIOLOGY-DIAGNOSTIC	54.00		1,959	8.00	
9.00					9.00	
	0		0	239,079		
D - LAUNDRY						
1.00	LAUNDRY & LINEN SERVICE	8.00		55,364	1.00	
2.00					2.00	
3.00					3.00	
4.00					4.00	
5.00					5.00	
6.00					6.00	
7.00		0.00	0	0	7.00	
8.00		0.00	0	0	8.00	
	0		0	55,364		
E - DEPRECIATION						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,937,367	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	1,937,367		
F - OTHER CAPITAL						
1.00	CAP REL COSTS-BLDG & FIXT	1.00		1,527,527	1.00	
2.00	CAP REL COSTS-BLDG & FIXT	1.00		33,123	2.00	
3.00	CAP REL COSTS-BLDG & FIXT	1.00		11,021	3.00	
	0		0	1,571,671		
H - EMPLOYEE BENEFITS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00		1,305,757	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	
	0		0	1,305,757		
I - HOUSEKEEPING						
1.00	HOUSEKEEPING	9.00	0	2,926	1.00	
2.00		0.00	0	0	2.00	
3.00		0.00	0	0	3.00	

Increases						
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
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
0			0	2,926		
N - EMERGENCY PREP						
1.00	ADULTS & PEDIATRICS	30.00	111,525	8,570		1.00
2.00	CARDIOPULMONARY	76.00	97,929	7,525		2.00
3.00	EMERGENCY	91.00	8,303	638		3.00
0			217,757	16,733		
O - STAFF RETENTION BONUS						
1.00	NURSING ADMINISTRATION	13.00	9,000	689		1.00
2.00	ADULTS & PEDIATRICS	30.00	45,000	3,443		2.00
3.00	OPERATING ROOM	50.00	30,000	2,295		3.00
4.00	CARDIOPULMONARY	76.00	44,000	3,366		4.00
5.00	EMERGENCY	91.00	93,000	7,115		5.00
	TOTALS		221,000	16,908		
500.00	Grand Total: Increases		531,665	6,313,784		500.00

RECLASSIFICATIONS

Provider CCN: 15-1316

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

Worksheet A-6

Date/Time Prepared:
5/26/2023 10:18 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
A - CAFETERIA							
1.00	DIETARY	10.00	92,908	71,949	0		1.00
	O		92,908	71,949			
B - DRUGS							
1.00	PHARMACY	15.00		944,907	0		1.00
2.00	ADULTS & PEDIATRICS	30.00		23,374	0		2.00
3.00	OPERATING ROOM	50.00		9,470	0		3.00
4.00	RADIOLOGY-DIAGNOSTIC	54.00		48,874	0		4.00
5.00	PHYSICAL THERAPY	66.00		652	0		5.00
6.00	ELECTROCARDIOLOGY	69.00		1,745	0		6.00
7.00	CARDIOPULMONARY	76.00		5,236	0		7.00
8.00	EMERGENCY	91.00		61,772	0		8.00
	O		0	1,096,030			
C - MEDICAL SUPPLIES							
1.00	OPERATION OF PLANT	7.00		22,028	0		1.00
2.00	PHARMACY	15.00		1,109	0		2.00
3.00	ADULTS & PEDIATRICS	30.00		43,212	0		3.00
4.00	OPERATING ROOM	50.00		89,951	0		4.00
5.00	LABORATORY	60.00		9,467	0		5.00
6.00	PHYSICAL THERAPY	66.00		4,522	0		6.00
7.00	ELECTROCARDIOLOGY	69.00		3,485	0		7.00
8.00	CARDIOPULMONARY	76.00		9,184	0		8.00
9.00	EMERGENCY	91.00		56,121	0		9.00
	O		0	239,079			
D - LAUNDRY							
1.00	CENTRAL SERVICES & SUPPLY	14.00		7,360	0		1.00
2.00	PHARMACY	15.00		91	0		2.00
3.00	ADULTS & PEDIATRICS	30.00		9,124	0		3.00
4.00	OPERATING ROOM	50.00		7,719	0		4.00
5.00	RADIOLOGY-DIAGNOSTIC	54.00		6,801	0		5.00
6.00	PHYSICAL THERAPY	66.00		4,011	0		6.00
7.00	ELECTROCARDIOLOGY	69.00		1,801	0		7.00
8.00	EMERGENCY	91.00		18,457	0		8.00
	O		0	55,364			
E - DEPRECIATION							
1.00	ADMINISTRATIVE & GENERAL	5.00		488,422	9		1.00
2.00	OPERATION OF PLANT	7.00		740,408	0		2.00
3.00	DIETARY	10.00		3,631	0		3.00
4.00	NURSING ADMINISTRATION	13.00		190	0		4.00
5.00	PHARMACY	15.00		1,247	0		5.00
6.00	ADULTS & PEDIATRICS	30.00		94,097	0		6.00
7.00	OPERATING ROOM	50.00		293,937	0		7.00
8.00	RADIOLOGY-DIAGNOSTIC	54.00		178,501	0		8.00
9.00	PHYSICAL THERAPY	66.00		5,606	0		9.00
10.00	ELECTROCARDIOLOGY	69.00		21,849	0		10.00
11.00	CARDIOPULMONARY	76.00		50,992	0		11.00
12.00	EMERGENCY	91.00		58,487	0		12.00
	O		0	1,937,367			
F - OTHER CAPITAL							
1.00	ADMINISTRATIVE & GENERAL	5.00		1,527,527	11		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00		33,123	12		2.00
3.00	ADMINISTRATIVE & GENERAL	5.00		11,021	13		3.00
	O		0	1,571,671			
H - EMPLOYEE BENEFITS							
1.00	ADMINISTRATIVE & GENERAL	5.00		22,663	0		1.00
2.00	OPERATION OF PLANT	7.00		157,810	0		2.00
3.00	HOUSEKEEPING	9.00		125,046	0		3.00
4.00	DIETARY	10.00		51,426	0		4.00
5.00	NURSING ADMINISTRATION	13.00		131,614	0		5.00
6.00	PHARMACY	15.00		79,388	0		6.00
7.00	ADULTS & PEDIATRICS	30.00		168,317	0		7.00
8.00	OPERATING ROOM	50.00		30,341	0		8.00
9.00	RADIOLOGY-DIAGNOSTIC	54.00		106,075	0		9.00
10.00	SPEECH PATHOLOGY	68.00		10,939	0		10.00
11.00	ELECTROCARDIOLOGY	69.00		10,506	0		11.00
12.00	CARDIOPULMONARY	76.00		145,791	0		12.00
13.00	EMERGENCY	91.00		265,841	0		13.00
	O		0	1,305,757			
I - HOUSEKEEPING							
1.00	NURSING ADMINISTRATION	13.00		2	0		1.00
2.00	PHARMACY	15.00		547	0		2.00
3.00	ADULTS & PEDIATRICS	30.00		800	0		3.00
4.00	OPERATING ROOM	50.00		66	0		4.00
5.00	RADIOLOGY-DIAGNOSTIC	54.00		568	0		5.00

RECLASSIFICATIONS

Provider CCN: 15-1316

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

Worksheet A-6

Date/Time Prepared:
5/26/2023 10:18 am

Decreases							
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
6.00	PHYSICAL THERAPY	66.00		119	0		6.00
7.00	CARDIOPULMONARY	76.00		76	0		7.00
8.00	EMERGENCY	91.00		748	0		8.00
			0	2,926			
N - EMERGENCY PREP							
1.00	NURSING ADMINISTRATION	13.00	217,757	16,733	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
			217,757	16,733			
O - STAFF RETENTION BONUS							
1.00	ADMINISTRATIVE & GENERAL	5.00	221,000	16,908	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
	TOTALS		221,000	16,908			
500.00	Grand Total : Decreases		531,665	6,313,784			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-1316

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

Worksheet A-7
Part I
Date/Time Prepared:
5/26/2023 10:18 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
			1.00	2.00	3.00		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	1,030,133	0	0	0	0	1.00
2.00	Land Improvements	23,434	0	0	0	0	2.00
3.00	Buildings and Fixtures	26,047,259	1,466,029	0	1,466,029	0	3.00
4.00	Building Improvements	1,690,988	165,036	0	165,036	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	9,169,107	231,229	0	231,229	143,329	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	37,960,921	1,862,294	0	1,862,294	143,329	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	37,960,921	1,862,294	0	1,862,294	143,329	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	1,030,133	0				1.00
2.00	Land Improvements	23,434	0				2.00
3.00	Buildings and Fixtures	27,513,288	1,646				3.00
4.00	Building Improvements	1,856,024	471,471				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	9,257,007	4,038,508				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	39,679,886	4,511,625				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	39,679,886	4,511,625				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-1316

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

Worksheet A-7
Part II
Date/Time Prepared:
5/26/2023 10:18 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
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
3.00	Total (sum of lines 1-2)	0	0				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-1316

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

Worksheet A-7
Part III
Date/Time Prepared:
5/26/2023 10:18 am

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	39,679,886	0	39,679,886	1.000000	0	1.00
3.00	Total (sum of lines 1-2)	39,679,886	0	39,679,886	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	2,000,418	0	1.00
3.00	Total (sum of lines 1-2)	0	0	0	2,000,418	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	1,002,228	33,123	11,021	0	3,046,790	1.00
3.00	Total (sum of lines 1-2)	1,002,228	33,123	11,021	0	3,046,790	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 15-1316

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

Worksheet A-8

Date/Time Prepared:
5/26/2023 10:18 am

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			Wkst. A-7 Ref.
			Cost Center		Line #	
			1.00	2.00	3.00	
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	107,909	CAP REL COSTS-BLDG & FIXT		1.00	11 1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	*** Cost Center Deleted ***		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	-398,236				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	2,125,512				0 12.00
13.00 Laundry and linen service		0			0.00	0 13.00
14.00 Cafeteria-employees and guests		0			0.00	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	*** Cost Center Deleted ***		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	A	1,141	CAP REL COSTS-BLDG & FIXT		1.00	9 26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP		0	*** Cost Center Deleted ***		2.00	0 27.00
28.00 Non-physician Anesthetist		0	*** Cost Center Deleted ***		19.00	28.00
29.00 Physicians' assistant		0			0.00	0 29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY		67.00	30.00
30.99 Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS		30.00	30.99
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY		68.00	31.00
32.00 CAH HIT Adjustment for Depreciation and Interest		0			0.00	0 32.00
33.00 EMPLOYEE BENEFITS	A	-1,305,757	EMPLOYEE BENEFITS DEPARTMENT		4.00	0 33.00

Provider CCN: 15-1316
 Period: From 01/01/2022 To 12/31/2022
 Worksheet A-8
 Date/Time Prepared: 5/26/2023 10:18 am

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
			Cost Center	Line #		
			1.00	2.00		
33.01 MEDICAID HAF FEES	A	-1,445,956	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02 MISCELLANEOUS INCOME	B	-2,568	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03 CONTRIBUTION EXPENSE	A	-175	ADULTS & PEDIATRICS	30.00	0	33.03
33.04 CONTRIBUTION EXPENSE	A	-490	PHARMACY	15.00	0	33.04
33.05 CONTRIBUTION EXPENSE	A	-1,319	ADMINISTRATIVE & GENERAL	5.00	0	33.05
33.06 DEPRECIATION ON CAPITALIZED ASSETS	A	61,910	CAP REL COSTS-BLDG & FIXT	1.00	9	33.06
33.07 START UP COST NEW HOSPITAL	A	276,621	ADMINISTRATIVE & GENERAL	5.00	0	33.07
33.08 TELEPHONE EQUIPMENT	A	-360	EMERGENCY	91.00	0	33.08
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-581,768				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: 15-1316

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

Worksheet A-8-1

Date/Time Prepared: 5/26/2023 10:18 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	894,319	1,527,527	1.00
2.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE	1,120,085	0	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE	4,450,191	4,152,460	3.00
3.01	5.00	ADMINISTRATIVE & GENERAL	RELATED PARTY	1,120,454	611,524	3.01
3.02	7.00	OPERATION OF PLANT	RELATED PARTY	105,898	57,891	3.02
4.00	13.00	NURSING ADMINISTRATION	RELATED PARTY	218,220	44,192	4.00
4.01	14.00	CENTRAL SERVICES & SUPPLY	RELATED PARTY	259,677	115,867	4.01
4.02	15.00	PHARMACY	RELATED PARTY	430,169	204,411	4.02
4.03	30.00	ADULTS & PEDIATRICS	RELATED PARTY	73,870	57,495	4.03
4.04	50.00	OPERATING ROOM	RELATED PARTY	152,185	65,654	4.04
4.05	54.00	RADIOLOGY-DIAGNOSTIC	RELATED PARTY	121,731	0	4.05
4.06	76.00	CARDIOPULMONARY	RELATED PARTY	82,044	59,644	4.06
4.07	91.00	EMERGENCY	RELATED PARTY	33,303	39,969	4.07
4.08	10.00	DIETARY	SHARED EMPLOYEES	1,200	1,200	4.08
4.09	30.00	ADULTS & PEDIATRICS	SHARED EMPLOYEES	279,412	279,412	4.09
4.10	50.00	OPERATING ROOM	SHARED EMPLOYEES	163,133	163,133	4.10
4.11	60.00	LABORATORY	SHARED EMPLOYEES	1,837,827	1,837,827	4.11
4.12	91.00	EMERGENCY	SHARED EMPLOYEES	362,163	362,163	4.12
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			11,705,881	9,580,369	5.00

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

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

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

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

6.00	B	IU HEALTH	100.00		0.00	6.00
7.00	B	IUH ARNETT	1.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					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: 15-1316

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

Worksheet A-8-1

Date/Time Prepared:
5/26/2023 10:18 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	-633,208	11		1.00
2.00	1,120,085	0		2.00
3.00	297,731	0		3.00
3.01	508,930	0		3.01
3.02	48,007	0		3.02
4.00	174,028	0		4.00
4.01	143,810	0		4.01
4.02	225,758	0		4.02
4.03	16,375	0		4.03
4.04	86,531	0		4.04
4.05	121,731	0		4.05
4.06	22,400	0		4.06
4.07	-6,666	0		4.07
4.08	0	0		4.08
4.09	0	0		4.09
4.10	0	0		4.10
4.11	0	0		4.11
4.12	0	0		4.12
5.00	2,125,512			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			6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 15-1316

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

Worksheet A-8-2

Date/Time Prepared:
5/26/2023 10:18 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	263,088	263,088	0	0	0	1.00
2.00	50.00	OPERATING ROOM	130,948	130,948	0	0	0	2.00
3.00	76.00	CARDIOPULMONARY	4,200	4,200	0	0	0	3.00
4.00	91.00	EMERGENCY	1,098,951	0	1,098,951	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,497,187	398,236	1,098,951			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	50.00	OPERATING ROOM	0	0	0	0	0	2.00
3.00	76.00	CARDIOPULMONARY	0	0	0	0	0	3.00
4.00	91.00	EMERGENCY	0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	1.00	2.00	15.00	16.00	17.00	18.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	263,088	1.00
2.00	50.00	OPERATING ROOM	0	0	0	130,948	2.00
3.00	76.00	CARDIOPULMONARY	0	0	0	4,200	3.00
4.00	91.00	EMERGENCY	0	0	0	0	4.00
5.00	0.00		0	0	0	0	5.00
6.00	0.00		0	0	0	0	6.00
7.00	0.00		0	0	0	0	7.00
8.00	0.00		0	0	0	0	8.00
9.00	0.00		0	0	0	0	9.00
10.00	0.00		0	0	0	0	10.00
200.00			0	0	0	398,236	200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 15-1316		Period: From 01/01/2022 To 12/31/2022		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 5/26/2023 10:18 am	
				Physical Therapy		Cost	
						1.00	
PART I - GENERAL INFORMATION							
1.00	Total number of weeks worked (excluding aides) (see instructions)					52	1.00
2.00	Line 1 multiplied by 15 hours per week					780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					305	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					118	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					6.05	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	7,362.81	964.92	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	92.74	60.28	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	46.37	46.37	30.14			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
Part II - SALARY EQUIVALENCY COMPUTATION							
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					682,827	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)					58,165	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					740,992	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					740,992	20.00
If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.							
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					0	22.00
23.00	Total salary equivalency (see instructions)					740,992	23.00
PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE							
Standard Travel Allowance							
24.00	Therapists (line 3 times column 2, line 11)					14,143	24.00
25.00	Assistants (line 4 times column 3, line 11)					3,557	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					17,700	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					2,559	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					20,259	28.00
Optional Travel Allowance and Optional Travel Expense							
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					20,259	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
PART IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE							
Standard Travel Expense							
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
Optional Travel Allowance and Optional Travel Expense							
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.							
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 15-1316		Period: From 01/01/2022 To 12/31/2022		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 5/26/2023 10:18 am		
						Physical Therapy	Cost	
						1.00		
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)						0	46.00
		Therapists	Assistants	Aides	Trainees	Total		
		1.00	2.00	3.00	4.00	5.00		
PART V - OVERTIME COMPUTATION								
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00	
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00	0.00	48.00	
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00	0.00	49.00	
CALCULATION OF LIMIT								
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00	
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50 (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00	
DETERMINATION OF OVERTIME ALLOWANCE								
52.00	Adjusted hourly salary equivalency amount (see instructions)	92.74	60.28	0.00	0.00		52.00	
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00	
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00	
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00	
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00	
						1.00		
Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT								
57.00	Salary equivalency amount (from line 23)						740,992	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))						20,259	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)						0	59.00
60.00	Overtime allowance (from column 5, line 56)						0	60.00
61.00	Equipment cost (see instructions)						0	61.00
62.00	Supplies (see instructions)						0	62.00
63.00	Total allowance (sum of lines 57-62)						761,251	63.00
64.00	Total cost of outside supplier services (from your records)						632,238	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)						0	65.00
LINE 33 CALCULATION								
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others						17,700	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others						2,559	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27						20,259	100.02
LINE 34 CALCULATION								
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others						2,559	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others						0	101.01
101.02	Line 34 = sum of lines 27 and 31						2,559	101.02
LINE 35 CALCULATION								
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others						0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others						0	102.01
102.02	Line 35 = sum of lines 31 and 32						0	102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 15-1316		Period: From 01/01/2022 To 12/31/2022		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 5/26/2023 10:18 am	
				Occupational Therapy		Cost	
						1.00	
PART I - GENERAL INFORMATION							
1.00	Total number of weeks worked (excluding aides) (see instructions)					52	1.00
2.00	Line 1 multiplied by 15 hours per week					780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					161	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					203	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					6.05	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	1,397.42	1,737.02	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	92.74	63.99	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	46.37	46.37	32.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
Part II - SALARY EQUIVALENCY COMPUTATION							
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					129,597	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)					111,152	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					240,749	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					240,749	20.00
If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.							
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					0	22.00
23.00	Total salary equivalency (see instructions)					240,749	23.00
PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE							
Standard Travel Allowance							
24.00	Therapists (line 3 times column 2, line 11)					7,466	24.00
25.00	Assistants (line 4 times column 3, line 11)					6,496	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					13,962	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					2,202	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					16,164	28.00
Optional Travel Allowance and Optional Travel Expense							
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					16,164	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE							
Standard Travel Expense							
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
Optional Travel Allowance and Optional Travel Expense							
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.							
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 15-1316		Period: From 01/01/2022 To 12/31/2022		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 5/26/2023 10:18 am	
				Occupational Therapy		Cost	
						1.00	
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
PART V - OVERTIME COMPUTATION							
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
CALCULATION OF LIMIT							
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
DETERMINATION OF OVERTIME ALLOWANCE							
52.00	Adjusted hourly salary equivalency amount (see instructions)	92.74	63.99	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00
						1.00	
Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT							
57.00	Salary equivalency amount (from line 23)					240,749	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))					16,164	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)					0	59.00
60.00	Overtime allowance (from column 5, line 56)					0	60.00
61.00	Equipment cost (see instructions)					0	61.00
62.00	Supplies (see instructions)					0	62.00
63.00	Total allowance (sum of lines 57-62)					256,913	63.00
64.00	Total cost of outside supplier services (from your records)					206,708	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)					0	65.00
LINE 33 CALCULATION							
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others					13,962	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					2,202	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27					16,164	100.02
LINE 34 CALCULATION							
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					2,202	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					0	101.01
101.02	Line 34 = sum of lines 27 and 31					2,202	101.02
LINE 35 CALCULATION							
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others					0	102.01
102.02	Line 35 = sum of lines 31 and 32					0	102.02

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-1316

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

Worksheet B
Part I
Date/Time Prepared:
5/26/2023 10:18 am

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
		BLDG & FIXT					
	0	1.00		4.00	4A	5.00	
GENERAL SERVICE COST CENTERS							
1.00 00100	CAP REL COSTS-BLDG & FIXT	3,046,790	3,046,790				1.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	1,162,561	5,962	1,168,523			4.00
5.00 00500	ADMINISTRATIVE & GENERAL	6,027,144	480,783	7,946	6,515,873	6,515,873	5.00
7.00 00700	OPERATION OF PLANT	1,669,185	327,082	79,250	2,075,517	634,778	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	55,364	0	0	55,364	16,933	8.00
9.00 00900	HOUSEKEEPING	543,704	45,641	45,413	634,758	194,135	9.00
10.00 01000	DIETARY	223,185	65,110	20,218	308,513	94,356	10.00
11.00 01100	CAFETERIA	164,857	49,545	14,653	229,055	70,054	11.00
13.00 01300	NURSING ADMINISTRATION	1,361,666	42,264	163,926	1,567,856	479,515	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	387,948	102,573	0	490,521	150,021	14.00
15.00 01500	PHARMACY	828,617	75,294	46,113	950,024	290,556	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000	ADULTS & PEDIATRICS	1,966,223	432,821	208,238	2,607,282	797,414	30.00
ANCILLARY SERVICE COST CENTERS							
50.00 05000	OPERATING ROOM	667,280	340,168	54,332	1,061,780	324,736	50.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	1,291,717	204,460	145,430	1,641,607	502,071	54.00
60.00 06000	LABORATORY	1,995,210	82,470	0	2,077,680	635,440	60.00
66.00 06600	PHYSICAL THERAPY	643,086	179,027	0	822,113	251,436	66.00
67.00 06700	OCCUPATIONAL THERAPY	206,708	11,925	0	218,633	66,867	67.00
68.00 06800	SPEECH PATHOLOGY	104,457	13,033	15,318	132,808	40,618	68.00
69.00 06900	ELECTROCARDIOLOGY	76,778	23,111	5,155	105,044	32,127	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	47,896	0	0	47,896	14,649	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	47,580	0	0	47,580	14,552	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	494,143	0	0	494,143	151,129	73.00
73.01 07301	ONCOLOGY DRUGS	601,887	0	0	601,887	184,082	73.01
76.00 03160	CARDIOPULMONARY	1,116,588	159,135	139,466	1,415,189	432,823	76.00
77.00 07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
OUTPATIENT SERVICE COST CENTERS							
90.00 09000	CLINIC	0	0	0	0	0	90.00
91.00 09100	EMERGENCY	3,090,057	406,386	223,065	3,719,508	1,137,581	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
101.00 10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
102.00 10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	27,820,631	3,046,790	1,168,523	27,820,631	6,515,873	118.00
NONREIMBURSABLE COST CENTERS							
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00 19100	RESEARCH	0	0	0	0	0	191.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.02 19202	MOB	0	0	0	0	0	192.02
193.00 19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00 07950	LEASED SPACE	0	0	0	0	0	194.00
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)	27,820,631	3,046,790	1,168,523	27,820,631	6,515,873	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-1316

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

Worksheet B
Part I
Date/Time Prepared:
5/26/2023 10:18 am

Cost Center Description		OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
		7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT	2,710,295				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	72,297			8.00
9.00	00900	HOUSEKEEPING	55,397	0	884,290		9.00
10.00	01000	DIETARY	79,029	0	26,323	508,221	10.00
11.00	01100	CAFETERIA	60,136	0	20,030	0	379,275
13.00	01300	NURSING ADMINISTRATION	51,298	0	17,086	0	44,999
14.00	01400	CENTRAL SERVICES & SUPPLY	124,499	0	41,468	0	0
15.00	01500	PHARMACY	91,389	0	30,440	0	14,838
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	525,345	72,297	174,981	508,221	68,489
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	412,884	0	137,523	0	18,850
54.00	05400	RADIOLOGY-DIAGNOSTIC	248,166	0	82,659	0	46,884
60.00	06000	LABORATORY	100,099	0	33,341	0	56,744
66.00	06600	PHYSICAL THERAPY	217,298	0	72,377	0	0
67.00	06700	OCCUPATIONAL THERAPY	14,474	0	4,821	0	0
68.00	06800	SPEECH PATHOLOGY	15,819	0	5,269	0	4,833
69.00	06900	ELECTROCARDIOLOGY	28,051	0	9,343	0	1,885
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
73.01	07301	ONCOLOGY DRUGS	0	0	0	0	0
76.00	03160	CARDIOPULMONARY	193,153	0	64,335	0	45,337
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	0
91.00	09100	EMERGENCY	493,258	0	164,294	0	76,416
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,710,295	72,297	884,290	508,221	379,275
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
191.00	19100	RESEARCH	0	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
192.02	19202	MOB	0	0	0	0	0
193.00	19300	NONPAID WORKERS	0	0	0	0	0
194.00	07950	LEASED SPACE	0	0	0	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118 through 201)	2,710,295	72,297	884,290	508,221	379,275

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-1316

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

Worksheet B
Part I
Date/Time Prepared:
5/26/2023 10:18 am

Cost Center Description		NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	
		13.00	14.00	15.00	16.00	24.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100						11.00
13.00	01300	2,160,754					13.00
14.00	01400	0	806,509				14.00
15.00	01500	0	4,003	1,381,250			15.00
16.00	01600	0	0	0	0		16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	949,580	124,928	21,006	0	5,849,543	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	146,812	88,103	7,484	0	2,198,172	50.00
54.00	05400	438	6,305	3,379	0	2,531,509	54.00
60.00	06000	0	36,968	0	0	2,940,272	60.00
66.00	06600	0	3,173	0	0	1,366,397	66.00
67.00	06700	0	0	0	0	304,795	67.00
68.00	06800	0	0	0	0	199,347	68.00
69.00	06900	0	12,141	0	0	188,591	69.00
71.00	07100	0	162,889	0	0	225,434	71.00
72.00	07200	0	161,814	0	0	223,946	72.00
73.00	07300	0	0	580,577	0	1,225,849	73.00
73.01	07301	0	0	707,166	0	1,493,135	73.01
76.00	03160	0	35,118	354	0	2,186,309	76.00
77.00	07700	0	0	0	0	0	77.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	0	0	0	0	90.00
91.00	09100	1,063,924	171,067	61,284	0	6,887,332	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	0	0	0	0	0	101.00
102.00	10200	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS							
118.00		2,160,754	806,509	1,381,250	0	27,820,631	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
191.00	19100	0	0	0	0	0	191.00
192.00	19200	0	0	0	0	0	192.00
192.02	19202	0	0	0	0	0	192.02
193.00	19300	0	0	0	0	0	193.00
194.00	07950	0	0	0	0	0	194.00
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		2,160,754	806,509	1,381,250	0	27,820,631	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-1316

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

Worksheet B
Part I
Date/Time Prepared:
5/26/2023 10:18 am

Cost Center Description		Intern & Residents Cost & Post Stepdown Adjustments	Total	
		25.00	26.00	
GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT		1.00
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
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	5,849,543
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	2,198,172
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,531,509
60.00	06000	LABORATORY	0	2,940,272
66.00	06600	PHYSICAL THERAPY	0	1,366,397
67.00	06700	OCCUPATIONAL THERAPY	0	304,795
68.00	06800	SPEECH PATHOLOGY	0	199,347
69.00	06900	ELECTROCARDIOLOGY	0	188,591
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	225,434
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	223,946
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,225,849
73.01	07301	ONCOLOGY DRUGS	0	1,493,135
76.00	03160	CARDIOPULMONARY	0	2,186,309
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0
OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0
91.00	09100	EMERGENCY	0	6,887,332
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0
OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	0
102.00	10200	OPIOID TREATMENT PROGRAM	0	0
SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	27,820,631
NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0
191.00	19100	RESEARCH	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0
192.02	19202	MOB	0	0
193.00	19300	NONPAID WORKERS	0	0
194.00	07950	LEASED SPACE	0	0
200.00		Cross Foot Adjustments	0	0
201.00		Negative Cost Centers	0	0
202.00		TOTAL (sum lines 118 through 201)	0	27,820,631

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-1316

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

Worksheet B
Part II
Date/Time Prepared:
5/26/2023 10:18 am

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	
		BLDG & FIXT					
	0	1.00		2A	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00 00100	CAP REL COSTS-BLDG & FIXT						1.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	5,962	5,962	5,962		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	0	480,783	480,783	41	480,824	5.00
7.00 00700	OPERATION OF PLANT	0	327,082	327,082	405	46,842	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	0	0	0	1,250	8.00
9.00 00900	HOUSEKEEPING	0	45,641	45,641	232	14,326	9.00
10.00 01000	DIETARY	0	65,110	65,110	103	6,963	10.00
11.00 01100	CAFETERIA	0	49,545	49,545	75	5,170	11.00
13.00 01300	NURSING ADMINISTRATION	0	42,264	42,264	837	35,385	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	102,573	102,573	0	11,071	14.00
15.00 01500	PHARMACY	0	75,294	75,294	235	21,441	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000	ADULTS & PEDIATRICS	0	432,821	432,821	1,063	58,844	30.00
ANCILLARY SERVICE COST CENTERS							
50.00 05000	OPERATING ROOM	0	340,168	340,168	277	23,963	50.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	204,460	204,460	742	37,049	54.00
60.00 06000	LABORATORY	0	82,470	82,470	0	46,891	60.00
66.00 06600	PHYSICAL THERAPY	0	179,027	179,027	0	18,554	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	11,925	11,925	0	4,934	67.00
68.00 06800	SPEECH PATHOLOGY	0	13,033	13,033	78	2,997	68.00
69.00 06900	ELECTROCARDIOLOGY	0	23,111	23,111	26	2,371	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	1,081	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	1,074	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	11,152	73.00
73.01 07301	ONCOLOGY DRUGS	0	0	0	0	13,584	73.01
76.00 03160	CARDIOPULMONARY	0	159,135	159,135	712	31,939	76.00
77.00 07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
OUTPATIENT SERVICE COST CENTERS							
90.00 09000	CLINIC	0	0	0	0	0	90.00
91.00 09100	EMERGENCY	0	406,386	406,386	1,136	83,943	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
101.00 10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
102.00 10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	0	3,046,790	3,046,790	5,962	480,824	118.00
NONREIMBURSABLE COST CENTERS							
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00 19100	RESEARCH	0	0	0	0	0	191.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.02 19202	MOB	0	0	0	0	0	192.02
193.00 19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00 07950	LEASED SPACE	0	0	0	0	0	194.00
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	3,046,790	3,046,790	5,962	480,824	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-1316

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

Worksheet B
Part II
Date/Time Prepared:
5/26/2023 10:18 am

Cost Center Description		OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
		7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT	374,329				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	1,250			8.00
9.00	00900	HOUSEKEEPING	7,651	0	67,850		9.00
10.00	01000	DIETARY	10,915	0	2,020	85,111	10.00
11.00	01100	CAFETERIA	8,306	0	1,537	0	64,633
13.00	01300	NURSING ADMINISTRATION	7,085	0	1,311	0	7,668
14.00	01400	CENTRAL SERVICES & SUPPLY	17,195	0	3,182	0	0
15.00	01500	PHARMACY	12,622	0	2,336	0	2,529
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	72,557	1,250	13,426	85,111	11,671
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	57,025	0	10,552	0	3,212
54.00	05400	RADIOLOGY-DIAGNOSTIC	34,275	0	6,342	0	7,990
60.00	06000	LABORATORY	13,825	0	2,558	0	9,670
66.00	06600	PHYSICAL THERAPY	30,012	0	5,553	0	0
67.00	06700	OCCUPATIONAL THERAPY	1,999	0	370	0	0
68.00	06800	SPEECH PATHOLOGY	2,185	0	404	0	824
69.00	06900	ELECTROCARDIOLOGY	3,874	0	717	0	321
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
73.01	07301	ONCOLOGY DRUGS	0	0	0	0	0
76.00	03160	CARDIOPULMONARY	26,677	0	4,936	0	7,726
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	0
91.00	09100	EMERGENCY	68,126	0	12,606	0	13,022
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	374,329	1,250	67,850	85,111	64,633
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
191.00	19100	RESEARCH	0	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
192.02	19202	MOB	0	0	0	0	0
193.00	19300	NONPAID WORKERS	0	0	0	0	0
194.00	07950	LEASED SPACE	0	0	0	0	0
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118 through 201)	374,329	1,250	67,850	85,111	64,633

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-1316

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

Worksheet B
Part II
Date/Time Prepared:
5/26/2023 10:18 am

Cost Center Description		NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	
		13.00	14.00	15.00	16.00	24.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100						11.00
13.00	01300	94,550					13.00
14.00	01400	0	134,021				14.00
15.00	01500	0	665	115,122			15.00
16.00	01600	0	0	0	0		16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	41,552	20,760	1,751	0	740,806	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	6,424	14,640	624	0	456,885	50.00
54.00	05400	19	1,048	282	0	292,207	54.00
60.00	06000	0	6,143	0	0	161,557	60.00
66.00	06600	0	527	0	0	233,673	66.00
67.00	06700	0	0	0	0	19,228	67.00
68.00	06800	0	0	0	0	19,521	68.00
69.00	06900	0	2,018	0	0	32,438	69.00
71.00	07100	0	27,068	0	0	28,149	71.00
72.00	07200	0	26,889	0	0	27,963	72.00
73.00	07300	0	0	48,389	0	59,541	73.00
73.01	07301	0	0	58,939	0	72,523	73.01
76.00	03160	0	5,836	29	0	236,990	76.00
77.00	07700	0	0	0	0	0	77.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	0	0	0	0	90.00
91.00	09100	46,555	28,427	5,108	0	665,309	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	0	0	0	0	0	101.00
102.00	10200	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS							
118.00		94,550	134,021	115,122	0	3,046,790	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
191.00	19100	0	0	0	0	0	191.00
192.00	19200	0	0	0	0	0	192.00
192.02	19202	0	0	0	0	0	192.02
193.00	19300	0	0	0	0	0	193.00
194.00	07950	0	0	0	0	0	194.00
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		94,550	134,021	115,122	0	3,046,790	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-1316

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

Worksheet B
Part II
Date/Time Prepared:
5/26/2023 10:18 am

Cost Center Description		Intern & Residents Cost & Post Stepdown Adjustments	Total	
		25.00	26.00	
GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT		1.00
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
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	740,806
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	456,885
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	292,207
60.00	06000	LABORATORY	0	161,557
66.00	06600	PHYSICAL THERAPY	0	233,673
67.00	06700	OCCUPATIONAL THERAPY	0	19,228
68.00	06800	SPEECH PATHOLOGY	0	19,521
69.00	06900	ELECTROCARDIOLOGY	0	32,438
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	28,149
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	27,963
73.00	07300	DRUGS CHARGED TO PATIENTS	0	59,541
73.01	07301	ONCOLOGY DRUGS	0	72,523
76.00	03160	CARDIOPULMONARY	0	236,990
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0
OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0
91.00	09100	EMERGENCY	0	665,309
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0
OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	0
102.00	10200	OPIOID TREATMENT PROGRAM	0	0
SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	3,046,790
NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0
191.00	19100	RESEARCH	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0
192.02	19202	MOB	0	0
193.00	19300	NONPAID WORKERS	0	0
194.00	07950	LEASED SPACE	0	0
200.00		Cross Foot Adjustments	0	0
201.00		Negative Cost Centers	0	0
202.00		TOTAL (sum lines 118 through 201)	0	3,046,790

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-1316

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

Worksheet B-1

Date/Time Prepared:
5/26/2023 10:18 am

Cost Center Description	CAPITAL RELATED COSTS	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
	BLDG & FIXT (SQUARE FEET)					
	1.00	4.00	5A	5.00	7.00	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	57,744				1.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	113	7,409,131			4.00
5.00 00500	ADMINISTRATIVE & GENERAL	9,112	50,385	-6,515,873	21,304,758	5.00
7.00 00700	OPERATION OF PLANT	6,199	502,495	0	2,075,517	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	0	0	55,364	8.00
9.00 00900	HOUSEKEEPING	865	287,948	0	634,758	9.00
10.00 01000	DIETARY	1,234	128,196	0	308,513	10.00
11.00 01100	CAFETERIA	939	92,908	0	229,055	11.00
13.00 01300	NURSING ADMINISTRATION	801	1,039,388	0	1,567,856	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	1,944	0	0	490,521	14.00
15.00 01500	PHARMACY	1,427	292,382	0	950,024	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	8,203	1,320,355	0	2,607,282	30.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	6,447	344,494	0	1,061,780	50.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	3,875	922,112	0	1,641,607	54.00
60.00 06000	LABORATORY	1,563	0	0	2,077,680	60.00
66.00 06600	PHYSICAL THERAPY	3,393	0	0	822,113	66.00
67.00 06700	OCCUPATIONAL THERAPY	226	0	0	218,633	67.00
68.00 06800	SPEECH PATHOLOGY	247	97,124	0	132,808	68.00
69.00 06900	ELECTROCARDIOLOGY	438	32,688	0	105,044	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	47,896	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	47,580	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	494,143	73.00
73.01 07301	ONCOLOGY DRUGS	0	0	0	601,887	73.01
76.00 03160	CARDIOPULMONARY	3,016	884,300	0	1,415,189	76.00
77.00 07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	77.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	0	0	0	90.00
91.00 09100	EMERGENCY	7,702	1,414,356	0	3,719,508	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS						
101.00 10100	HOME HEALTH AGENCY	0	0	0	0	101.00
102.00 10200	OPIOID TREATMENT PROGRAM	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	57,744	7,409,131	-6,515,873	21,304,758	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
191.00 19100	RESEARCH	0	0	0	0	191.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
192.02 19202	MOB	0	0	0	0	192.02
193.00 19300	NONPAID WORKERS	0	0	0	0	193.00
194.00 07950	LEASED SPACE	0	0	0	0	194.00
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers					201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	3,046,790	1,168,523		6,515,873	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	52.763750	0.157714		0.305841	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)		5,962		480,824	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)		0.000805		0.022569	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: 15-1316

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

Worksheet B-1

Date/Time Prepared:
5/26/2023 10:18 am

Cost Center Description		LAUNDRY & LINEN SERVICE (PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (DIRECT NURSING HOURS)	
		8.00	9.00	10.00	11.00	13.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800	1,538					8.00
9.00	00900	0	41,455				9.00
10.00	01000	0	1,234	1,538			10.00
11.00	01100	0	939	0	7,847		11.00
13.00	01300	0	801	0	931	64,155	13.00
14.00	01400	0	1,944	0	0	0	14.00
15.00	01500	0	1,427	0	307	0	15.00
16.00	01600	0	0	0	0	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	1,538	8,203	1,538	1,417	28,194	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	6,447	0	390	4,359	50.00
54.00	05400	0	3,875	0	970	13	54.00
60.00	06000	0	1,563	0	1,174	0	60.00
66.00	06600	0	3,393	0	0	0	66.00
67.00	06700	0	226	0	0	0	67.00
68.00	06800	0	247	0	100	0	68.00
69.00	06900	0	438	0	39	0	69.00
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	0	0	73.00
73.01	07301	0	0	0	0	0	73.01
76.00	03160	0	3,016	0	938	0	76.00
77.00	07700	0	0	0	0	0	77.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	0	0	0	0	90.00
91.00	09100	0	7,702	0	1,581	31,589	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	0	0	0	0	0	101.00
102.00	10200	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS							
118.00		1,538	41,455	1,538	7,847	64,155	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
191.00	19100	0	0	0	0	0	191.00
192.00	19200	0	0	0	0	0	192.00
192.02	19202	0	0	0	0	0	192.02
193.00	19300	0	0	0	0	0	193.00
194.00	07950	0	0	0	0	0	194.00
200.00							200.00
201.00							201.00
202.00		72,297	884,290	508,221	379,275	2,160,754	202.00
203.00		47.007152	21.331323	330.442783	48.333758	33.680212	203.00
204.00		1,250	67,850	85,111	64,633	94,550	204.00
205.00		0.812744	1.636715	55.338752	8.236651	1.473774	205.00
206.00							206.00
207.00							207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-1316

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

Worksheet B-1
Date/Time Prepared:
5/26/2023 10:18 am

Cost Center Description		CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
		14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS					
1.00	00100				1.00
4.00	00400				4.00
5.00	00500				5.00
7.00	00700				7.00
8.00	00800				8.00
9.00	00900				9.00
10.00	01000				10.00
11.00	01100				11.00
13.00	01300				13.00
14.00	01400	237,147			14.00
15.00	01500	1,177	1,175,616		15.00
16.00	01600	0	0	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	36,734	17,879	0	30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	25,906	6,370	0	50.00
54.00	05400	1,854	2,876	0	54.00
60.00	06000	10,870	0	0	60.00
66.00	06600	933	0	0	66.00
67.00	06700	0	0	0	67.00
68.00	06800	0	0	0	68.00
69.00	06900	3,570	0	0	69.00
71.00	07100	47,896	0	0	71.00
72.00	07200	47,580	0	0	72.00
73.00	07300	0	494,143	0	73.00
73.01	07301	0	601,887	0	73.01
76.00	03160	10,326	301	0	76.00
77.00	07700	0	0	0	77.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	0	0	0	90.00
91.00	09100	50,301	52,160	0	91.00
92.00	09200				92.00
OTHER REIMBURSABLE COST CENTERS					
101.00	10100	0	0	0	101.00
102.00	10200	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS					
118.00		237,147	1,175,616	0	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	0	0	0	190.00
191.00	19100	0	0	0	191.00
192.00	19200	0	0	0	192.00
192.02	19202	0	0	0	192.02
193.00	19300	0	0	0	193.00
194.00	07950	0	0	0	194.00
200.00					200.00
201.00					201.00
202.00		806,509	1,381,250	0	202.00
203.00		3.400882	1.174916	0.000000	203.00
204.00		134,021	115,122	0	204.00
205.00		0.565139	0.097925	0.000000	205.00
206.00					206.00
207.00					207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-1316

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

Worksheet C
Part I
Date/Time Prepared:
5/26/2023 10:18 am

Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		
				Total Costs	RCE Disallowance	
		1.00	2.00	3.00	4.00	5.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	5,849,543		5,849,543	0	0 30.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	2,198,172		2,198,172	0	0 50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	2,531,509		2,531,509	0	0 54.00
60.00	06000 LABORATORY	2,940,272		2,940,272	0	0 60.00
66.00	06600 PHYSICAL THERAPY	1,366,397	0	1,366,397	0	0 66.00
67.00	06700 OCCUPATIONAL THERAPY	304,795	0	304,795	0	0 67.00
68.00	06800 SPEECH PATHOLOGY	199,347	0	199,347	0	0 68.00
69.00	06900 ELECTROCARDIOLOGY	188,591		188,591	0	0 69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	225,434		225,434	0	0 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	223,946		223,946	0	0 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1,225,849		1,225,849	0	0 73.00
73.01	07301 ONCOLOGY DRUGS	1,493,135		1,493,135	0	0 73.01
76.00	03160 CARDIOPULMONARY	2,186,309		2,186,309	0	0 76.00
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0		0	0	0 77.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	0		0	0	0 90.00
91.00	09100 EMERGENCY	6,887,332		6,887,332	0	0 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1,406,475		1,406,475	0	0 92.00
OTHER REIMBURSABLE COST CENTERS						
101.00	10100 HOME HEALTH AGENCY	0		0		0 101.00
102.00	10200 OPIOID TREATMENT PROGRAM	0		0		0 102.00
200.00	Subtotal (see instructions)	29,227,106	0	29,227,106	0	0 200.00
201.00	Less Observation Beds	1,406,475		1,406,475		0 201.00
202.00	Total (see instructions)	27,820,631	0	27,820,631	0	0 202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-1316

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

Worksheet C
Part I
Date/Time Prepared:
5/26/2023 10:18 am

		Title XVIII			Hospital	Cost	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
	Inpatient	Outpatient	Total (col. 6 + col. 7)				
	6.00	7.00	8.00				9.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	3,228,777		3,228,777		30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	5,221,219	5,221,219	0.421007	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	536,468	10,796,106	11,332,574	0.223383	54.00
60.00	06000	LABORATORY	899,721	5,523,531	6,423,252	0.457754	60.00
66.00	06600	PHYSICAL THERAPY	386,795	2,642,399	3,029,194	0.451076	66.00
67.00	06700	OCCUPATIONAL THERAPY	177,350	922,303	1,099,653	0.277174	67.00
68.00	06800	SPEECH PATHOLOGY	82,328	596,625	678,953	0.293609	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,005,754	1,005,754	0.187512	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	139,653	139,653	1.614244	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	291,773	291,773	0.767535	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,325,041	1,770,675	3,095,716	0.395982	73.00
73.01	07301	ONCOLOGY DRUGS	0	4,842,245	4,842,245	0.308356	73.01
76.00	03160	CARDIOPULMONARY	1,045,931	3,757,250	4,803,181	0.455179	76.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0.000000	77.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0.000000	90.00
91.00	09100	EMERGENCY	486,696	25,486,872	25,973,568	0.265167	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	2,369,781	2,369,781	0.593504	92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	0	0		101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0		102.00
200.00		Subtotal (see instructions)	8,169,107	65,366,186	73,535,293		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	8,169,107	65,366,186	73,535,293		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-1316	Period: From 01/01/2022 To 12/31/2022	Worksheet C Part I Date/Time Prepared: 5/26/2023 10:18 am
Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital Cost
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.000000		50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000 LABORATORY	0.000000		60.00
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 PATIENTS	0.000000		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000		73.00
73.01	07301 ONCOLOGY DRUGS	0.000000		73.01
76.00	03160 CARDIOPULMONARY	0.000000		76.00
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0.000000		77.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0.000000		90.00
91.00	09100 EMERGENCY	0.000000		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
OTHER REIMBURSABLE COST CENTERS				
101.00	10100 HOME HEALTH AGENCY			101.00
102.00	10200 OPIOID TREATMENT PROGRAM			102.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-1316

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

Worksheet C
Part I
Date/Time Prepared:
5/26/2023 10:18 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	5,849,543		5,849,543	0	5,849,543 30.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	2,198,172		2,198,172	0	2,198,172 50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	2,531,509		2,531,509	0	2,531,509 54.00
60.00	06000 LABORATORY	2,940,272		2,940,272	0	2,940,272 60.00
66.00	06600 PHYSICAL THERAPY	1,366,397	0	1,366,397	0	1,366,397 66.00
67.00	06700 OCCUPATIONAL THERAPY	304,795	0	304,795	0	304,795 67.00
68.00	06800 SPEECH PATHOLOGY	199,347	0	199,347	0	199,347 68.00
69.00	06900 ELECTROCARDIOLOGY	188,591		188,591	0	188,591 69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	225,434		225,434	0	225,434 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	223,946		223,946	0	223,946 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1,225,849		1,225,849	0	1,225,849 73.00
73.01	07301 ONCOLOGY DRUGS	1,493,135		1,493,135	0	1,493,135 73.01
76.00	03160 CARDIOPULMONARY	2,186,309		2,186,309	0	2,186,309 76.00
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0		0	0	0 77.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	0		0	0	0 90.00
91.00	09100 EMERGENCY	6,887,332		6,887,332	0	6,887,332 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1,406,475		1,406,475		1,406,475 92.00
OTHER REIMBURSABLE COST CENTERS						
101.00	10100 HOME HEALTH AGENCY	0		0		0 101.00
102.00	10200 OPIOID TREATMENT PROGRAM	0		0		0 102.00
200.00	Subtotal (see instructions)	29,227,106	0	29,227,106	0	29,227,106 200.00
201.00	Less Observation Beds	1,406,475		1,406,475		1,406,475 201.00
202.00	Total (see instructions)	27,820,631	0	27,820,631	0	27,820,631 202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-1316

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

Worksheet C
Part I
Date/Time Prepared:
5/26/2023 10:18 am

		Title XIX			Hospital	Cost	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
	Inpatient	Outpatient	Total (col. 6 + col. 7)				
	6.00	7.00	8.00				9.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	3,228,777		3,228,777		30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	5,221,219	5,221,219	0.421007	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	536,468	10,796,106	11,332,574	0.223383	54.00
60.00	06000	LABORATORY	899,721	5,523,531	6,423,252	0.457754	60.00
66.00	06600	PHYSICAL THERAPY	386,795	2,642,399	3,029,194	0.451076	66.00
67.00	06700	OCCUPATIONAL THERAPY	177,350	922,303	1,099,653	0.277174	67.00
68.00	06800	SPEECH PATHOLOGY	82,328	596,625	678,953	0.293609	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,005,754	1,005,754	0.187512	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	139,653	139,653	1.614244	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	291,773	291,773	0.767535	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,325,041	1,770,675	3,095,716	0.395982	73.00
73.01	07301	ONCOLOGY DRUGS	0	4,842,245	4,842,245	0.308356	73.01
76.00	03160	CARDIOPULMONARY	1,045,931	3,757,250	4,803,181	0.455179	76.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0.000000	77.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0.000000	90.00
91.00	09100	EMERGENCY	486,696	25,486,872	25,973,568	0.265167	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	2,369,781	2,369,781	0.593504	92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	0	0		101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0		102.00
200.00		Subtotal (see instructions)	8,169,107	65,366,186	73,535,293		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	8,169,107	65,366,186	73,535,293		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-1316	Period: From 01/01/2022 To 12/31/2022	Worksheet C Part I Date/Time Prepared: 5/26/2023 10:18 am
Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital
		11.00		Cost
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.000000		50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000 LABORATORY	0.000000		60.00
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 PATIENTS	0.000000		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000		73.00
73.01	07301 ONCOLOGY DRUGS	0.000000		73.01
76.00	03160 CARDIOPULMONARY	0.000000		76.00
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0.000000		77.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0.000000		90.00
91.00	09100 EMERGENCY	0.000000		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
OTHER REIMBURSABLE COST CENTERS				
101.00	10100 HOME HEALTH AGENCY			101.00
102.00	10200 OPIOID TREATMENT PROGRAM			102.00
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: 15-1316	Period: From 01/01/2022 To 12/31/2022	Worksheet D Part II Date/Time Prepared: 5/26/2023 10:18 am
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Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
Title XVIII Hospital Cost								
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	456,885	5,221,219	0.087505	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	292,207	11,332,574	0.025785	184,630	4,761	54.00
60.00	06000	LABORATORY	161,557	6,423,252	0.025152	300,893	7,568	60.00
66.00	06600	PHYSICAL THERAPY	233,673	3,029,194	0.077140	88,795	6,850	66.00
67.00	06700	OCCUPATIONAL THERAPY	19,228	1,099,653	0.017486	14,888	260	67.00
68.00	06800	SPEECH PATHOLOGY	19,521	678,953	0.028752	26,421	760	68.00
69.00	06900	ELECTROCARDIOLOGY	32,438	1,005,754	0.032252	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	28,149	139,653	0.201564	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	27,963	291,773	0.095838	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	59,541	3,095,716	0.019233	468,250	9,006	73.00
73.01	07301	ONCOLOGY DRUGS	72,523	4,842,245	0.014977	0	0	73.01
76.00	03160	CARDIOPULMONARY	236,990	4,803,181	0.049340	401,300	19,800	76.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0.000000	0	0	77.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
91.00	09100	EMERGENCY	665,309	25,973,568	0.025615	29,439	754	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	178,120	2,369,781	0.075163	0	0	92.00
200.00		Total (lines 50 through 199)	2,484,104	70,306,516		1,514,616	49,759	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-1316	Period: From 01/01/2022 To 12/31/2022	Worksheet D Part IV Date/Time Prepared: 5/26/2023 10:18 am
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Cost Center Description	Title XVIII				Hospital		
	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	Cost	
	1.00	2A	2.00	3A	3.00		
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	60.00
66.00	06600	PHYSICAL THERAPY	0	0	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	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
73.01	07301	ONCOLOGY DRUGS	0	0	0	0	73.01
76.00	03160	CARDIOPULMONARY	0	0	0	0	76.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	77.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
200.00		Total (Lines 50 through 199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-1316	Period: From 01/01/2022 To 12/31/2022	Worksheet D Part IV Date/Time Prepared: 5/26/2023 10:18 am
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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	5,221,219	0.000000	50.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	11,332,574	0.000000	54.00
60.00 06000 LABORATORY	0	0	0	6,423,252	0.000000	60.00
66.00 06600 PHYSICAL THERAPY	0	0	0	3,029,194	0.000000	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	1,099,653	0.000000	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	678,953	0.000000	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	1,005,754	0.000000	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	139,653	0.000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	291,773	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	3,095,716	0.000000	73.00
73.01 07301 ONCOLOGY DRUGS	0	0	0	4,842,245	0.000000	73.01
76.00 03160 CARDIOPULMONARY	0	0	0	4,803,181	0.000000	76.00
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0.000000	77.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	0	0	0	0	0.000000	90.00
91.00 09100 EMERGENCY	0	0	0	25,973,568	0.000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	2,369,781	0.000000	92.00
200.00 Total (lines 50 through 199)	0	0	0	70,306,516		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-1316	Period: From 01/01/2022 To 12/31/2022	Worksheet D Part IV Date/Time Prepared: 5/26/2023 10:18 am
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Cost Center Description		Title XVIII			Hospital		Cost
		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0.000000	0	0	0	0	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	184,630	0	0	0	54.00
60.00	06000 LABORATORY	0.000000	300,893	0	0	0	60.00
66.00	06600 PHYSICAL THERAPY	0.000000	88,795	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	14,888	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	26,421	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	468,250	0	0	0	73.00
73.01	07301 ONCOLOGY DRUGS	0.000000	0	0	0	0	73.01
76.00	03160 CARDIOPULMONARY	0.000000	401,300	0	0	0	76.00
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	0	0	77.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0.000000	0	0	0	0	90.00
91.00	09100 EMERGENCY	0.000000	29,439	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
200.00	Total (lines 50 through 199)		1,514,616	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-1316	Period: From 01/01/2022 To 12/31/2022	Worksheet D Part V Date/Time Prepared: 5/26/2023 10:18 am
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Cost Center Description		Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges	Costs			
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
		1.00	2.00	3.00			
			4.00	5.00			
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0.421007	0	855,033	0	0	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.223383	0	1,782,431	0	0	54.00
60.00	06000 LABORATORY	0.457754	0	765,786	0	0	60.00
66.00	06600 PHYSICAL THERAPY	0.451076	0	522,467	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.277174	0	161,929	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.293609	0	44,765	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.187512	0	307,015	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1.614244	0	38,497	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.767535	0	8,030	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.395982	0	230,960	21,177	0	73.00
73.01	07301 ONCOLOGY DRUGS	0.308356	0	1,467,551	0	0	73.01
76.00	03160 CARDIOPULMONARY	0.455179	0	905,016	0	0	76.00
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	0	0	77.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0.000000	0	0	0	0	90.00
91.00	09100 EMERGENCY	0.265167	0	3,558,408	118,000	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.593504	0	457,363	0	0	92.00
200.00	Subtotal (see instructions)		0	11,105,251	139,177	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	11,105,251	139,177	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-1316	Period: From 01/01/2022 To 12/31/2022	Worksheet D Part V Date/Time Prepared: 5/26/2023 10:18 am
	Title XVIII	Hospital	Cost

Cost Center Description	Costs			Cost
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	359,975	0		50.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	398,165	0		54.00
60.00 06000 LABORATORY	350,542	0		60.00
66.00 06600 PHYSICAL THERAPY	235,672	0		66.00
67.00 06700 OCCUPATIONAL THERAPY	44,883	0		67.00
68.00 06800 SPEECH PATHOLOGY	13,143	0		68.00
69.00 06900 ELECTROCARDIOLOGY	57,569	0		69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	62,144	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	6,163	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	91,456	8,386		73.00
73.01 07301 ONCOLOGY DRUGS	452,528	0		73.01
76.00 03160 CARDIOPULMONARY	411,944	0		76.00
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0		77.00
OUTPATIENT SERVICE COST CENTERS				
90.00 09000 CLINIC	0	0		90.00
91.00 09100 EMERGENCY	943,572	31,290		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	271,447	0		92.00
200.00 Subtotal (see instructions)	3,699,203	39,676		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00 Net Charges (line 200 - line 201)	3,699,203	39,676		202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-1316	Period: From 01/01/2022 To 12/31/2022	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 5/26/2023 10:18 am
Cost Center Description			Cost	
			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		1,987	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		1,720	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)		1,271	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		137	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		130	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)		520	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)		137	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)		5,849,543	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)		32,557	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)		461,704	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		5,387,839	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		5,387,839	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)		3,132.46	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,628,879	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		1,628,879	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 15-1316	Period: From 01/01/2022 To 12/31/2022	Worksheet D-1 Date/Time Prepared: 5/26/2023 10:18 am	
Cost Center Description			Title XVIII		Hospital	Cost
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
42.00	1.00	2.00	3.00	4.00	5.00	42.00
NURSERY (title V & XIX only)						
Intensive Care Type Inpatient Hospital Units						
43.00						43.00
INTENSIVE CARE UNIT						
44.00						44.00
CORONARY CARE UNIT						
45.00						45.00
BURN INTENSIVE CARE UNIT						
46.00						46.00
SURGICAL INTENSIVE CARE UNIT						
47.00						47.00
OTHER SPECIAL CARE (SPECIFY)						
Cost Center Description					1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)				606,803	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)				2,235,682	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)				429,147	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				429,147	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)				449	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)				3,132.46	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)				1,406,475	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-1316		Period: From 01/01/2022 To 12/31/2022		Worksheet D-1 Date/Time Prepared: 5/26/2023 10:18 am	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	740,806	5,849,543	0.126643	1,406,475	178,120	90.00
91.00	Nursing Program cost	0	5,849,543	0.000000	1,406,475	0	91.00
92.00	Allied health cost	0	5,849,543	0.000000	1,406,475	0	92.00
93.00	All other Medical Education	0	5,849,543	0.000000	1,406,475	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-1316	Period: From 01/01/2022 To 12/31/2022	Worksheet D-1 Date/Time Prepared: 5/26/2023 10:18 am
Cost Center Description		Title XIX	Hospital	Cost
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			1,987 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			1,720 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)			1,271 4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			137 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			130 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)			19 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)			5,849,543 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)			32,557 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)			461,704 26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			5,387,839 27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)			0 28.00
29.00	Private room charges (excluding swing-bed charges)			0 29.00
30.00	Semi-private room charges (excluding swing-bed charges)			0 30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)			0.000000 31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00 32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00 33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)			0.00 34.00
35.00	Average per diem private room cost differential (line 34 x line 31)			0.00 35.00
36.00	Private room cost differential adjustment (line 3 x line 35)			0 36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)			5,387,839 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)			3,132.46 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			59,517 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)			59,517 41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 15-1316	Period: From 01/01/2022 To 12/31/2022	Worksheet D-1 Date/Time Prepared: 5/26/2023 10:18 am	
Cost Center Description			Title XIX		Hospital	Cost
	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					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)				24,445	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)				83,962	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)				449	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)				3,132.46	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)				1,406,475	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-1316

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

Worksheet D-1

Date/Time Prepared:
5/26/2023 10:18 am

Cost Center Description	Cost	Title XIX		Hospital	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	740,806	5,849,543	0.126643	1,406,475	178,120	90.00
91.00 Nursing Program cost	0	5,849,543	0.000000	1,406,475	0	91.00
92.00 Allied health cost	0	5,849,543	0.000000	1,406,475	0	92.00
93.00 All other Medical Education	0	5,849,543	0.000000	1,406,475	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-1316	Period: From 01/01/2022 To 12/31/2022	Worksheet D-3 Date/Time Prepared: 5/26/2023 10:18 am
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Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		1,184,928		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.421007	0	0	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.223383	184,630	41,243	54.00
60.00	06000 LABORATORY	0.457754	300,893	137,735	60.00
66.00	06600 PHYSICAL THERAPY	0.451076	88,795	40,053	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.277174	14,888	4,127	67.00
68.00	06800 SPEECH PATHOLOGY	0.293609	26,421	7,757	68.00
69.00	06900 ELECTROCARDIOLOGY	0.187512	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1.614244	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.767535	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.395982	468,250	185,419	73.00
73.01	07301 ONCOLOGY DRUGS	0.308356	0	0	73.01
76.00	03160 CARDIOPULMONARY	0.455179	401,300	182,663	76.00
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	77.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.000000	0	0	90.00
91.00	09100 EMERGENCY	0.265167	29,439	7,806	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.593504	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		1,514,616	606,803	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net charges (line 200 minus line 201)		1,514,616		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-1316 Component CCN: 15-Z316	Period: From 01/01/2022 To 12/31/2022	Worksheet D-3 Date/Time Prepared: 5/26/2023 10:18 am	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.421007	0	0	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.223383	11,154	2,492	54.00
60.00	06000 LABORATORY	0.457754	17,753	8,127	60.00
66.00	06600 PHYSICAL THERAPY	0.451076	108,337	48,868	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.277174	74,493	20,648	67.00
68.00	06800 SPEECH PATHOLOGY	0.293609	3,936	1,156	68.00
69.00	06900 ELECTROCARDIOLOGY	0.187512	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1.614244	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.767535	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.395982	26,401	10,454	73.00
73.01	07301 ONCOLOGY DRUGS	0.308356	0	0	73.01
76.00	03160 CARDIOPULMONARY	0.455179	6,813	3,101	76.00
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	77.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.000000	0	0	90.00
91.00	09100 EMERGENCY	0.265167	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.593504	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		248,887	94,846	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net charges (line 200 minus line 201)		248,887		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-1316	Period: From 01/01/2022 To 12/31/2022	Worksheet D-3 Date/Time Prepared: 5/26/2023 10:18 am	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		42,297		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.421007	0	0	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.223383	17,478	3,904	54.00
60.00	06000 LABORATORY	0.457754	13,716	6,279	60.00
66.00	06600 PHYSICAL THERAPY	0.451076	3,735	1,685	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.277174	957	265	67.00
68.00	06800 SPEECH PATHOLOGY	0.293609	2,228	654	68.00
69.00	06900 ELECTROCARDIOLOGY	0.187512	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1.614244	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.767535	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.395982	10,538	4,173	73.00
73.01	07301 ONCOLOGY DRUGS	0.308356	0	0	73.01
76.00	03160 CARDIOPULMONARY	0.455179	2,689	1,224	76.00
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	77.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.000000	0	0	90.00
91.00	09100 EMERGENCY	0.265167	23,612	6,261	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.593504	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		74,953	24,445	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net charges (line 200 minus line 201)		74,953		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-1316	Period: From 01/01/2022 To 12/31/2022	Worksheet E Part B Date/Time Prepared: 5/26/2023 10:18 am
		Title XVIII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			3,738,879 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)			3,738,879 11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges			0 12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)			0 13.00
14.00	Total reasonable charges (sum of lines 12 and 13)			0 14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0 15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)			0 16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000 17.00
18.00	Total customary charges (see instructions)			0 18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)			0 19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)			0 20.00
21.00	Lesser of cost or charges (see instructions)			3,776,268 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)			25,980 25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)			1,884,393 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)			1,865,895 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)			1,865,895 30.00
31.00	Primary payer payments			4,865 31.00
32.00	Subtotal (line 30 minus line 31)			1,861,030 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)			291,713 34.00
35.00	Adjusted reimbursable bad debts (see instructions)			189,613 35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			151,916 36.00
37.00	Subtotal (see instructions)			2,050,643 37.00
38.00	MSP-LCC reconciliation amount from PS&R			0 38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 39.50
39.75	N95 respirator payment adjustment amount (see instructions)			0 39.75
39.97	Demonstration payment adjustment amount before sequestration			0 39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)			0 39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION			0 39.99
40.00	Subtotal (see instructions)			2,050,643 40.00
40.01	Sequestration adjustment (see instructions)			25,838 40.01
40.02	Demonstration payment adjustment amount after sequestration			0 40.02
40.03	Sequestration adjustment-PARHM or CHART pass-throughs			0 40.03
41.00	Interim payments			2,836,558 41.00
41.01	Interim payments-PARHM or CHART			0 41.01
42.00	Tentative settlement (for contractors use only)			0 42.00
42.01	Tentative settlement-PARHM or CHART (for contractor use only)			0 42.01
43.00	Balance due provider/program (see instructions)			-811,753 43.00
43.01	Balance due provider/program-PARHM (see instructions)			0 43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			158,641 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: 15-1316	Period: From 01/01/2022 To 12/31/2022	Worksheet E Part B Date/Time Prepared: 5/26/2023 10:18 am
Title XVIII		Hospital	Cost
			1.00
200.00	MEDI CARE PART B ANCI LLARY COSTS Part B Combined Billed Days		0 200.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-1316

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

Worksheet E-1
Part I
Date/Time Prepared:
5/26/2023 10:18 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		1,721,633		2,836,558	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						3.00
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01	
3.02			0		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50	
3.51			0		0	3.51	
3.52			0		0	3.52	
3.53			0		0	3.53	
3.54			0		0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,721,633		2,836,558	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		341,785		0	6.01	
6.02	SETTLEMENT TO PROGRAM		0		811,753	6.02	
7.00	Total Medicare program liability (see instructions)		2,063,418		2,024,805	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: 15-1316
Component CCN: 15-Z316

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

Worksheet E-1
Part I
Date/Time Prepared:
5/26/2023 10:18 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		468,055		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)		468,055		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		52,779		0		6.01
6.02	SETTLEMENT TO PROGRAM		0		0		6.02
7.00	Total Medicare program liability (see instructions)		520,834		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: 15-1316	Period: From 01/01/2022 To 12/31/2022	Worksheet E-1 Part II Date/Time Prepared: 5/26/2023 10:18 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: 15-1316	Period: From 01/01/2022 To 12/31/2022	Worksheet E-2
		Component CCN: 15-Z316	Date/Time Prepared: 5/26/2023 10:18 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)	433,438	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)	95,794	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	137	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)	529,232	0	8.00
9.00	Primary payer payments (see instructions)	0		9.00
10.00	Subtotal (line 8 minus line 9)	529,232	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)	529,232	0	12.00
13.00	Coinurance billed to program patients (from provider records) (exclude coinurance for physician professional services)	1,751	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (see instructions)	527,481	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)	527,481	0	19.00
19.01	Sequestration adjustment (see instructions)	6,647	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	468,055	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)	52,779	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	22,067	0	23.00
Rural Community Hospital Demonstration Project (\$410A Demonstration) Adjustment				
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
Cost Reimbursement				
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))			201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))			202.00
203.00	Total (sum of lines 201 and 202)			203.00
204.00	Medicare swing-bed SNF discharges (see instructions)			204.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)				
205.00	Medicare swing-bed SNF target amount			205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)			206.00
Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement				
207.00	Program reimbursement under the \$410A Demonstration (see instructions)			207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)			208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
Comparison of PPS versus Cost Reimbursement				
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)			215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-1316	Period: From 01/01/2022 To 12/31/2022	Worksheet E-3 Part V Date/Time Prepared: 5/26/2023 10:18 am
		Title XVIII	Hospital	Cost
				1.00
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT				
1.00	Inpatient services			2,235,682 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)			2,235,682 4.00
5.00	Primary payer payments			0 5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)			2,258,039 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)			2,258,039 19.00
20.00	Deductibles (exclude professional component)			178,796 20.00
21.00	Excess reasonable cost (from line 16)			0 21.00
22.00	Subtotal (line 19 minus line 20 and 21)			2,079,243 22.00
23.00	Coinsurance			6,224 23.00
24.00	Subtotal (line 22 minus line 23)			2,073,019 24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			25,737 25.00
26.00	Adjusted reimbursable bad debts (see instructions)			16,729 26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			4,112 27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)			2,089,748 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)			2,089,748 30.00
30.01	Sequestration adjustment (see instructions)			26,330 30.01
30.02	Demonstration payment adjustment amount after sequestration			0 30.02
30.03	Sequestration adjustment-PARHM or CHART			0 30.03
31.00	Interim payments			1,721,633 31.00
31.01	Interim payments-PARHM or CHART			0 31.01
32.00	Tentative settlement (for contractor use only)			0 32.00
32.01	Tentative settlement-PARHM or CHART (for contractor use only)			0 32.01
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)			341,785 33.00
33.01	Balance due provider/program-PARHM or CHART (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01)			0 33.01
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			94,098 34.00

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

Provider CCN: 15-1316

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

Worksheet G
Date/Time Prepared:
5/26/2023 10:18 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	-14,039,701	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	3,460,186	0	0	0	4.00
5.00	Other receivable	3,019,238	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	369,635	0	0	0	7.00
8.00	Prepaid expenses	58,467	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)	-7,132,175	0	0	0	11.00
FIXED ASSETS						
12.00	Land	1,030,133	0	0	0	12.00
13.00	Land improvements	23,434	0	0	0	13.00
14.00	Accumulated depreciation	-8,983	0	0	0	14.00
15.00	Buildings	27,513,288	0	0	0	15.00
16.00	Accumulated depreciation	-1,616,594	0	0	0	16.00
17.00	Leasehold improvements	927,373	0	0	0	17.00
18.00	Accumulated depreciation	-546,149	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	9,257,007	0	0	0	23.00
24.00	Accumulated depreciation	-6,562,795	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)	30,016,714	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	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	0	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	22,884,539	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	2,360,347	0	0	0	37.00
38.00	Salaries, wages, and fees payable	416,202	0	0	0	38.00
39.00	Payroll taxes payable	31,547	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	2,029,421	0	0	0	43.00
44.00	Other current liabilities	0	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	4,837,517	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	23,373,443	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	23,373,443	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	28,210,960	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	-5,326,421				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)	-5,326,421	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	22,884,539	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 15-1316

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

Worksheet G-1

Date/Time Prepared:
5/26/2023 10:18 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		-6,315,358		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		841,823			2.00
3.00	Total (sum of line 1 and line 2)		-5,473,535		0	3.00
4.00	ADDITIONS	0		0		4.00
5.00	NET INTERCOMPANY TRANSACTIONS	147,113		0		5.00
6.00	ROUNDING	1		0		6.00
7.00		0		0		7.00
8.00		0		0		8.00
9.00		0		0		9.00
10.00	Total additions (sum of line 4-9)		147,114		0	10.00
11.00	Subtotal (line 3 plus line 10)		-5,326,421		0	11.00
12.00	Deductions (debit adjustments) (specify)	0		0		12.00
13.00		0		0		13.00
14.00	NET INTERCOMPANY TRANSACTIONS	0		0		14.00
15.00		0		0		15.00
16.00		0		0		16.00
17.00		0		0		17.00
18.00	Total deductions (sum of lines 12-17)		0		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		-5,326,421		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		0			4.00
5.00	NET INTERCOMPANY TRANSACTIONS		0			5.00
6.00	ROUNDING		0			6.00
7.00			0			7.00
8.00			0			8.00
9.00			0			9.00
10.00	Total additions (sum of line 4-9)	0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0		11.00
12.00	Deductions (debit adjustments) (specify)		0			12.00
13.00			0			13.00
14.00	NET INTERCOMPANY TRANSACTIONS		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: 15-1316

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

Worksheet G-2
Parts I & II
Date/Time Prepared:
5/26/2023 10:18 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	2,927,337		2,927,337	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	301,440		301,440	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)	3,228,777		3,228,777	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	3,228,777		3,228,777	17.00
18.00	Ancillary services	4,453,634	37,509,533	41,963,167	18.00
19.00	Outpatient services	486,696	27,856,653	28,343,349	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		0	0	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	8,169,107	65,366,186	73,535,293	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		28,402,399		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)		28,402,399		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 15-1316

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

Worksheet G-3

Date/Time Prepared:
5/26/2023 10:18 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	73,535,293	1.00
2.00	Less contractual allowances and discounts on patients' accounts	44,249,904	2.00
3.00	Net patient revenues (line 1 minus line 2)	29,285,389	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	28,402,399	4.00
5.00	Net income from service to patients (line 3 minus line 4)	882,990	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	-41,167	24.00
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	-41,167	25.00
26.00	Total (line 5 plus line 25)	841,823	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)	841,823	29.00