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: 15-1306	Period: From 01/01/2022 To 12/31/2022	Worksheet S Parts I-III Date/Time Prepared: 5/30/2023 10:40 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 5/30/2023 Time: 10:40 am
2. [ ] Manually prepared cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no.

Contractor use only

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

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

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by IU HEALTH PAOLI HOSPITAL (15-1306) for the cost reporting period beginning 01/01/2022 and ending 12/31/2022 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR		CHECKBOX	ELECTRONIC SIGNATURE STATEMENT	
	1		2		
1	Michael Craig		Y	I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name	Michael Craig			2
3	Signatory Title	CHIEF FINANCIAL OFFICER			3
4	Date	(Dated when report is electronica			4

		Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	HOSPITAL	0	-99,069	-776,022	0	0	1.00
2.00	SUBPROVIDER - IPF	0	0	0		0	2.00
3.00	SUBPROVIDER - IRF	0	0	0		0	3.00
5.00	SWING BED - SNF	0	-10,449	0		0	5.00
6.00	SWING BED - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	RURAL HEALTH CLINIC I	0		5,007		0	10.00
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11.00
200.00	TOTAL	0	-109,518	-771,015	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: 15-1306 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-2 Part I | Date/Time Prepared: 5/30/2023 10:40 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 642 WEST HOSPITAL ROAD	PO Box:			1.00
2.00	City: PAOLI	State: IN	Zip Code: 47454	County: ORANGE	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	IU HEALTH PAOLI HOSPITAL	151306	99915	1	07/01/2001	N	O	P	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	IUHP SWING BEDS	15Z306	99915		07/01/2001	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC	IU HEALTH PAOLI FAMILY AND INTERNAL	158557	99915		12/07/2020	N	O	O	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) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or “N” for no.	N	N	N	22.03
22.04	Did this hospital receive a geographic reclassification from urban to rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.				22.04
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	3	N		23.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1306 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-2 Part I | Date/Time Prepared: 5/30/2023 10:40 am

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1306 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-2 Part I Date/Time Prepared: 5/30/2023 10:40 am

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1306 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-2 Part I Date/Time Prepared: 5/30/2023 10:40 am

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1306 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-2 Part I Date/Time Prepared: 5/30/2023 10:40 am

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

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1306 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-2 Part I Date/Time Prepared: 5/30/2023 10:40 am

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

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

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

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

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

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		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	40,345	0	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	Y		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	Y	5.00	122.00
123.00	Did the facility and/or its subproviders (if applicable) purchase professional services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, and/or management/consulting services, from an unrelated organization? In column 1, enter "Y" for yes or "N" for no. If column 1 is "Y", were the majority of the expenses, i.e., greater than 50% of total professional services expenses, for services purchased from unrelated organizations located in a CBSA outside of the main hospital CBSA? In column 2, enter "Y" for yes or "N" for no.			123.00
	Certified Transplant Center Information			
125.00	Does this facility operate a Medicare-certified transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare-certified kidney transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare-certified heart transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare-certified liver transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare-certified lung transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare-certified pancreas transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare-certified intestinal transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare-certified islet transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is a hospital-based organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	15H059	140.00

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name: INDIANA UNIVERSITY HEALTH	Contractor's Name: WISCONSIN PHYSICIAN SERVICES	Contractor's Number: 08101	141.00
142.00	Street: 340 WEST TENTH STREET	PO Box:		142.00
143.00	City: INDIANAPOLIS	State: IN	Zip Code: 46204	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

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		1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.	N	149.00

		Part A	Part B	Title V	Title XIX	
		1.00	2.00	3.00	4.00	
	Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)					
155.00	Hospital	N	N	N	N	155.00
156.00	Subprovider - IPF	N	N	N	N	156.00
157.00	Subprovider - IRF	N	N	N	N	157.00
158.00	SUBPROVIDER					158.00
159.00	SNF	N	N	N	N	159.00
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00
161.00	CMHC		N	N	N	161.00

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

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

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)		168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)	N	168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.00	169.00

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

		1.00	2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	Y	14	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1306 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-2 Part II | Date/Time Prepared: 5/30/2023 10:40 am

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

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

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

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

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

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

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

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		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DIRECTOR		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1306 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-3 Part I | Date/Time Prepared: 5/30/2023 10:40 am

	Component	Worksheet A Line No.	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	24	8,760	32,208.00	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)		24	8,760	32,208.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	0	0	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		24	8,760	32,208.00	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	88.00				0	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		24				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

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	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	536	39	1,342			1.00
2.00	HMO and other (see instructions)	357	325				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	25	0	25			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	64			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	561	39	1,431			7.00
8.00	INTENSIVE CARE UNIT	0	0	0			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		15	186			13.00
14.00	Total (see instructions)	561	54	1,617	0.00	124.66	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0	0	0	0.00	0.00	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			40			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	589	0	9,036	0.00	2.31	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	126.97	27.00
28.00	Observation Bed Days		13	615			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: 15-1306 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-3 Part I | Date/Time Prepared: 5/30/2023 10:40 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	156	8	382	1.00
2.00	HMO and other (see instructions)			84	126		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	156	8	382	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	0.00					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-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-1306 | Component CCN: 15-8557 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-8 | Date/Time Prepared: 5/30/2023 10:40 am

		RHC I	Cost
		1.00	
	Clinic Address and Identification		
1.00	Street		1.00

		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County				2.00

		1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban	0	3.00

		Grant Award	Date	
		1.00	2.00	
	Source of Federal Funds			
4.00	Community Health Center (Section 330(d), PHS Act)			4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)			5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)			6.00
7.00	Appalachian Regional Commission			7.00
8.00	Look-Alikes			8.00
9.00	OTHER (SPECIFY)			9.00

		1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)	N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	CLINIC						11.00

		1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?			12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.	N	0	13.00

		Provider name	CCN	
		1.00	2.00	
14.00	RHC/FQHC name, CCN			14.00

		Y/N	V	XVIII	XIX	Total Visits	
		1.00	2.00	3.00	4.00	5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)						15.00

			County				
			4.00				
2.00	City, State, ZIP Code, County						2.00

		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC						11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 15-1306
Component CCN: 15-8557

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

Worksheet S-8
Date/Time Prepared:
5/30/2023 10:40 am

RHC I

Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC						11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-1306 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-10 | Date/Time Prepared: 5/30/2023 10:40 am

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.342238	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	6,227,615	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	Y	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	23,427,310	6.00
7.00	Medicaid cost (line 1 times line 6)	8,017,716	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)	1,790,101	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)	5,025	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	40,263	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	13,780	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)	8,755	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)	1,798,856	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)	1,730,154	84,902	1,815,056	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	592,124	84,902	677,026	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)	592,124	84,902	677,026	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)	1,953,406	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	276,212	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	424,942	27.01
28.00	Non-Medicare bad debt expense (see instructions)	1,528,464	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	671,828	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,348,854	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	3,147,710	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1306 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A | Date/Time Prepared: 5/30/2023 10:40 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	559,770	559,770	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	835,729	835,729	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	95,753	95,753	1,993,463	2,089,216	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	760,508	6,907,465	7,667,973	-463,813	7,204,160	5.00
7.00	00700	OPERATION OF PLANT	427,686	1,600,892	2,028,578	-920,776	1,107,802	7.00
7.01	00701	UTILITIES	0	0	0	472,745	472,745	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	54,026	54,026	45,643	99,669	8.00
9.00	00900	HOUSEKEEPING	242,351	418,812	661,163	-126,293	534,870	9.00
10.00	01000	DIETARY	189,642	319,795	509,437	-247,039	262,398	10.00
11.00	01100	CAFETERIA	0	0	0	195,343	195,343	11.00
13.00	01300	NURSING ADMINISTRATION	1,336,733	338,988	1,675,721	-679,689	996,032	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	9,438	9,438	180,352	189,790	14.00
15.00	01500	PHARMACY	321,448	2,383,407	2,704,855	-2,144,976	559,879	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	362,101	348,574	710,675	-35,825	674,850	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,503,663	1,678,202	3,181,865	-335,903	2,845,962	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	187,738	48,778	236,516	-169,165	67,351	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	498,648	669,922	1,168,570	-256,902	911,668	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	41,669	20,115	61,784	248,546	310,330	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	972,860	1,052,107	2,024,967	-491,368	1,533,599	54.00
60.00	06000	LABORATORY	0	2,570,830	2,570,830	15,915	2,586,745	60.00
64.00	06400	INTRAVENOUS THERAPY	116,170	76,848	193,018	-28,903	164,115	64.00
65.00	06500	RESPIRATORY THERAPY	418,642	219,405	638,047	-65,855	572,192	65.00
66.00	06600	PHYSICAL THERAPY	603,113	350,076	953,189	-375,242	577,947	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	161,847	161,847	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	84,355	84,355	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	82,450	82,450	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	9,747	9,747	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	2,166,047	2,166,047	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	841,889	494,060	1,335,949	-384,620	951,329	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	65,900	7,332	73,232	15,395	88,627	90.00
90.01	09001	VISITING SPECIALTY CLINIC	255,178	156,311	411,489	-95,906	315,583	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	1,620,164	2,138,230	3,758,394	-244,808	3,513,586	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	10,766,103	21,959,366	32,725,469	264	32,725,733	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	VISITING SPECIALTY CLINIC	0	0	0	0	0	190.01
190.02	19002	OUTREACH	0	0	0	0	0	190.02
190.03	19003	FOUNDATION	0	0	0	0	0	190.03
190.04	19004	SPRING VALLEY FAMILY PRACTICE	0	0	0	0	0	190.04
190.05	19005	PAOLI FAMILY PRACTICE	0	5,234	5,234	-264	4,970	190.05
190.06	19006	OTHER PROPERTY	0	0	0	0	0	190.06
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		TOTAL (SUM OF LINES 118 through 199)	10,766,103	21,964,600	32,730,703	0	32,730,703	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1306 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A | Date/Time Prepared: 5/30/2023 10:40 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	0	559,770		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	835,729		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-345,013	1,744,203		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-532,370	6,671,790		5.00
7.00	00700	OPERATION OF PLANT	27,760	1,135,562		7.00
7.01	00701	UTILITIES	0	472,745		7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	99,669		8.00
9.00	00900	HOUSEKEEPING	0	534,870		9.00
10.00	01000	DIETARY	0	262,398		10.00
11.00	01100	CAFETERIA	0	195,343		11.00
13.00	01300	NURSING ADMINISTRATION	60,227	1,056,259		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	189,790		14.00
15.00	01500	PHARMACY	-205,452	354,427		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0		16.00
17.00	01700	SOCIAL SERVICE	0	0		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	-318,293	356,557		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-637,921	2,208,041		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0		31.00
43.00	04300	NURSERY	0	67,351		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	911,668		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	310,330		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54,759	1,588,358		54.00
60.00	06000	LABORATORY	18,750	2,605,495		60.00
64.00	06400	INTRAVENOUS THERAPY	0	164,115		64.00
65.00	06500	RESPIRATORY THERAPY	0	572,192		65.00
66.00	06600	PHYSICAL THERAPY	-70,971	506,976		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	161,847		67.00
68.00	06800	SPEECH PATHOLOGY	0	84,355		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	82,450		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	9,747		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,166,047		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0		75.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0		77.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	41,967	993,296		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
90.00	09000	CLINIC	0	88,627		90.00
90.01	09001	VISITING SPECIALTY CLINIC	-9,818	305,765		90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0	0		90.02
91.00	09100	EMERGENCY	237,435	3,751,021		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	0		95.00
101.00	10100	HOME HEALTH AGENCY	0	0		101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0		102.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-1,678,940	31,046,793		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
190.01	19001	VISITING SPECIALTY CLINIC	0	0		190.01
190.02	19002	OUTREACH	0	0		190.02
190.03	19003	FOUNDATION	0	0		190.03
190.04	19004	SPRING VALLEY FAMILY PRACTICE	0	0		190.04
190.05	19005	PAOLI FAMILY PRACTICE	0	4,970		190.05
190.06	19006	OTHER PROPERTY	0	0		190.06
191.00	19100	RESEARCH	0	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
193.00	19300	NONPAID WORKERS	0	0		193.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-1,678,940	31,051,763		200.00

RECLASSIFICATIONS | Provider CCN: 15-1306 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-6 | Date/Time Prepared: 5/30/2023 10:40 am

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - EMPLOYEE BENEFITS				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1,994,266	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
	0		0	1,994,266	
	B - BILLABLE DRUGS				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	2,166,047	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
	0		0	2,166,047	
	C - BILLABLE SUPPLIES				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	82,450	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
	0		0	82,450	
	D - IMPLANT SUPPLIES				
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	9,747	1.00
	0		0	9,747	
	E - NON-BILLABLE DRUGS				
1.00	PHARMACY	15.00		96,645	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	96,645	

RECLASSIFICATIONS | Provider CCN: 15-1306 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-6 | Date/Time Prepared: 5/30/2023 10:40 am

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	F - NON-BILLABLE MED SUPPLIES				
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	188,913	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	2,344	2.00
3.00	HOUSEKEEPING	9.00	0	91	3.00
4.00	PHARMACY	15.00	0	316	4.00
5.00	RADIOLOGY-DIAGNOSTIC	54.00	0	1,272	5.00
6.00	LABORATORY	60.00	0	75	6.00
7.00	PHYSICAL THERAPY	66.00	0	1,067	7.00
8.00	VISITING SPECIALTY CLINIC	90.01	0	72	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	194,150	
	G - CAPITAL RELATED COSTS				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	415,950	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	830,368	2.00
3.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	4,046	3.00
4.00	CAP REL COSTS-BLDG & FIXT	1.00	0	18,753	4.00
5.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	1,315	5.00
6.00	CAP REL COSTS-BLDG & FIXT	1.00	0	7,166	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
	0		0	1,277,598	
	H - LEASE EXPENSE				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	117,901	1.00
	0		0	117,901	
	I - COO/CNO				
1.00	ADMINISTRATIVE & GENERAL	5.00	212,000	0	1.00
	0		212,000	0	
	J - UTILITIES				
1.00	UTILITIES	7.01	0	472,745	1.00
2.00		0.00	0	0	2.00
	0		0	472,745	
	K - LAUNDRY				
1.00	LAUNDRY & LINEN SERVICE	8.00	0	45,643	1.00
	0		0	45,643	
	L - OBSTETRICS				
1.00	NURSERY	43.00	0	3,766	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	163,634	86,205	2.00
	0		163,634	89,971	
	M - CAFETERIA				
1.00	CAFETERIA	11.00	82,360	112,983	1.00
	0		82,360	112,983	
	N - OT AND ST				
1.00	OCCUPATIONAL THERAPY	67.00	118,440	43,407	1.00
2.00	SPEECH PATHOLOGY	68.00	61,731	22,624	2.00
	0		180,171	66,031	
	Q - BLOOD STORAGE				
1.00	LABORATORY	60.00	0	15,840	1.00
	0		0	15,840	
	R - PREMIUM WAGES				
1.00	ADULTS & PEDIATRICS	30.00	64,968	4,972	1.00
2.00	OPERATING ROOM	50.00	11,176	855	2.00
3.00	RESPIRATORY THERAPY	65.00	3,690	282	3.00
4.00	EMERGENCY	91.00	131,790	10,085	4.00
	0		211,624	16,194	
	S - SPOT RETENTION BONUS				
1.00	ADULTS & PEDIATRICS	30.00	152,594	12,739	1.00
2.00	OPERATING ROOM	50.00	61,866	5,165	2.00
3.00	RADIOLOGY-DIAGNOSTIC	54.00	7,376	616	3.00
4.00	INTRAVENOUS THERAPY	64.00	14,586	1,218	4.00
5.00	RESPIRATORY THERAPY	65.00	24,892	2,078	5.00

RECLASSIFICATIONS | Provider CCN: 15-1306 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-6 | Date/Time Prepared: 5/30/2023 10:40 am

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
6.00	CLINIC	90.00	16,595	1,385	6.00
7.00	EMERGENCY	91.00	109,674	9,156	7.00
	TOTALS		387,583	32,357	
500.00	Grand Total: Increases		1,237,372	6,790,568	500.00

RECLASSIFICATIONS | Provider CCN: 15-1306 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-6 | Date/Time Prepared: 5/30/2023 10:40 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - EMPLOYEE BENEFITS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	83,162	0		1.00
2.00	OPERATION OF PLANT	7.00	0	82,598	0		2.00
3.00	HOUSEKEEPING	9.00	0	71,087	0		3.00
4.00	DIETARY	10.00	0	45,654	0		4.00
5.00	NURSING ADMINISTRATION	13.00	0	210,289	0		5.00
6.00	PHARMACY	15.00	0	108,434	0		6.00
7.00	NONPHYSICIAN ANESTHETISTS	19.00	0	20,105	0		7.00
8.00	ADULTS & PEDIATRICS	30.00	0	333,499	0		8.00
9.00	OPERATING ROOM	50.00	0	111,454	0		9.00
10.00	DELIVERY ROOM & LABOR ROOM	52.00	0	55	0		10.00
11.00	RADIOLOGY-DIAGNOSTIC	54.00	0	152,055	0		11.00
12.00	INTRAVENOUS THERAPY	64.00	0	28,899	0		12.00
13.00	RESPIRATORY THERAPY	65.00	0	71,354	0		13.00
14.00	PHYSICAL THERAPY	66.00	0	119,924	0		14.00
15.00	RURAL HEALTH CLINIC	88.00	0	169,241	0		15.00
16.00	CLINIC	90.00	0	2,585	0		16.00
17.00	VISITING SPECIALTY CLINIC	90.01	0	80,626	0		17.00
18.00	EMERGENCY	91.00	0	303,245	0		18.00
	0		0	1,994,266			
	B - BILLABLE DRUGS						
1.00	OPERATION OF PLANT	7.00		93	0		1.00
2.00	HOUSEKEEPING	9.00		44	0		2.00
3.00	NURSING ADMINISTRATION	13.00		23	0		3.00
4.00	CENTRAL SERVICES & SUPPLY	14.00		43	0		4.00
5.00	PHARMACY	15.00		2,066,344	0		5.00
6.00	ADULTS & PEDIATRICS	30.00		5,333	0		6.00
7.00	NURSERY	43.00		339	0		7.00
8.00	OPERATING ROOM	50.00		3,053	0		8.00
9.00	RADIOLOGY-DIAGNOSTIC	54.00		73,623	0		9.00
10.00	INTRAVENOUS THERAPY	64.00		396	0		10.00
11.00	RESPIRATORY THERAPY	65.00		254	0		11.00
12.00	PHYSICAL THERAPY	66.00		35	0		12.00
13.00	VISITING SPECIALTY CLINIC	90.01		6,537	0		13.00
14.00	EMERGENCY	91.00		9,930	0		14.00
	0		0	2,166,047			
	C - BILLABLE SUPPLIES						
1.00	ADMINISTRATIVE & GENERAL	5.00		2	0		1.00
2.00	OPERATION OF PLANT	7.00		41	0		2.00
3.00	NURSING ADMINISTRATION	13.00		85	0		3.00
4.00	CENTRAL SERVICES & SUPPLY	14.00		7,643	0		4.00
5.00	PHARMACY	15.00		102	0		5.00
6.00	ADULTS & PEDIATRICS	30.00		4,930	0		6.00
7.00	NURSERY	43.00		1,207	0		7.00
8.00	OPERATING ROOM	50.00		47,023	0		8.00
9.00	DELIVERY ROOM & LABOR ROOM	52.00		127	0		9.00
10.00	RADIOLOGY-DIAGNOSTIC	54.00		528	0		10.00
11.00	INTRAVENOUS THERAPY	64.00		2,838	0		11.00
12.00	RESPIRATORY THERAPY	65.00		156	0		12.00
13.00	PHYSICAL THERAPY	66.00		3,432	0		13.00
14.00	VISITING SPECIALTY CLINIC	90.01		3,814	0		14.00
15.00	EMERGENCY	91.00		10,522	0		15.00
	0		0	82,450			
	D - IMPLANT SUPPLIES						
1.00	OPERATING ROOM	50.00	0	9,747	0		1.00
	0		0	9,747			
	E - NON-BILLABLE DRUGS						
1.00	ADMINISTRATIVE & GENERAL	5.00		87	0		1.00
2.00	OPERATION OF PLANT	7.00		275	0		2.00
3.00	NURSING ADMINISTRATION	13.00		31	0		3.00
4.00	CENTRAL SERVICES & SUPPLY	14.00		31	0		4.00
5.00	NONPHYSICIAN ANESTHETISTS	19.00		29	0		5.00
6.00	ADULTS & PEDIATRICS	30.00		15,946	0		6.00
7.00	NURSERY	43.00		987	0		7.00
8.00	OPERATING ROOM	50.00		6,114	0		8.00
9.00	RADIOLOGY-DIAGNOSTIC	54.00		7,941	0		9.00
10.00	INTRAVENOUS THERAPY	64.00		5,835	0		10.00
11.00	VISITING SPECIALTY CLINIC	90.01		1	0		11.00
12.00	EMERGENCY	91.00		59,368	0		12.00
	0		0	96,645			
	F - NON-BILLABLE MED SUPPLIES						
1.00	OPERATION OF PLANT	7.00	0	143	0		1.00
2.00	DIETARY	10.00	0	7	0		2.00
3.00	NURSING ADMINISTRATION	13.00	0	8,699	0		3.00

RECLASSIFICATIONS | Provider CCN: 15-1306 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-6 | Date/Time Prepared: 5/30/2023 10:40 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
4.00	NONPHYSICIAN ANESTHETISTS	19.00	0	431	0		4.00
5.00	ADULTS & PEDIATRICS	30.00	0	32,243	0		5.00
6.00	NURSERY	43.00	0	26,620	0		6.00
7.00	OPERATING ROOM	50.00	0	18,447	0		7.00
8.00	DELIVERY ROOM & LABOR ROOM	52.00	0	1,111	0		8.00
9.00	INTRAVENOUS THERAPY	64.00	0	6,739	0		9.00
10.00	RESPIRATORY THERAPY	65.00	0	17,124	0		10.00
11.00	RURAL HEALTH CLINIC	88.00	0	6,697	0		11.00
12.00	EMERGENCY	91.00	0	75,889	0		12.00
	0		0	194,150			
	G - CAPITAL RELATED COSTS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	803	9		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	57,065	9		2.00
3.00	OPERATION OF PLANT	7.00	0	399,067	10		3.00
4.00	HOUSEKEEPING	9.00	0	9,610	12		4.00
5.00	DIETARY	10.00	0	6,035	12		5.00
6.00	NURSING ADMINISTRATION	13.00	0	20,744	13		6.00
7.00	CENTRAL SERVICES & SUPPLY	14.00	0	844	0		7.00
8.00	PHARMACY	15.00	0	67,057	0		8.00
9.00	NONPHYSICIAN ANESTHETISTS	19.00	0	15,260	0		9.00
10.00	ADULTS & PEDIATRICS	30.00	0	68,801	0		10.00
11.00	NURSERY	43.00	0	597	0		11.00
12.00	OPERATING ROOM	50.00	0	140,126	0		12.00
13.00	RADIOLOGY-DIAGNOSTIC	54.00	0	266,485	0		13.00
14.00	RESPIRATORY THERAPY	65.00	0	7,909	0		14.00
15.00	PHYSICAL THERAPY	66.00	0	6,716	0		15.00
16.00	RURAL HEALTH CLINIC	88.00	0	158,656	0		16.00
17.00	VISITING SPECIALTY CLINIC	90.01	0	5,000	0		17.00
18.00	EMERGENCY	91.00	0	46,559	0		18.00
19.00	PAOLI FAMILY PRACTICE	190.05	0	264	0		19.00
	0		0	1,277,598			
	H - LEASE EXPENSE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	117,901	10		1.00
	0		0	117,901			
	I - COO/CNO						
1.00	NURSING ADMINISTRATION	13.00	212,000	0	0		1.00
	0		212,000	0			
	J - UTILITIES						
1.00	OPERATION OF PLANT	7.00	0	422,719	0		1.00
2.00	RURAL HEALTH CLINIC	88.00	0	50,026	0		2.00
	0		0	472,745			
	K - LAUNDRY						
1.00	HOUSEKEEPING	9.00	0	45,643	0		1.00
	0		0	45,643			
	L - OBSTETRICS						
1.00	ADULTS & PEDIATRICS	30.00	20,453	89,971	0		1.00
2.00	NURSERY	43.00	143,181	0	0		2.00
	0		163,634	89,971			
	M - CAFETERIA						
1.00	DIETARY	10.00	82,360	112,983	0		1.00
	0		82,360	112,983			
	N - OT AND ST						
1.00	PHYSICAL THERAPY	66.00	180,171	66,031	0		1.00
2.00		0.00	0	0	0		2.00
	0		180,171	66,031			
	Q - BLOOD STORAGE						
1.00	OPERATION OF PLANT	7.00	0	15,840	0		1.00
	0		0	15,840			
	R - PREMIUM WAGES						
1.00	NURSING ADMINISTRATION	13.00	211,624	16,194	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
	0		211,624	16,194			
	S - SPOT RETENTION BONUS						
1.00	ADMINISTRATIVE & GENERAL	5.00	387,583	32,357	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
	TOTALS		387,583	32,357			
500.00	Grand Total: Decreases		1,237,372	6,790,568			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1306 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-7 Part I | Date/Time Prepared: 5/30/2023 10:40 am

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	183,505	0	0	0	0	1.00
2.00	Land Improvements	625,604	0	0	0	0	2.00
3.00	Buildings and Fixtures	8,531,552	0	0	0	0	3.00
4.00	Building Improvements	1,939,739	1,587,556	0	1,587,556	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	12,208,031	1,092,858	0	1,092,858	219,864	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	23,488,431	2,680,414	0	2,680,414	219,864	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	23,488,431	2,680,414	0	2,680,414	219,864	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	183,505	0	1.00
2.00	Land Improvements	625,604	258,464	2.00
3.00	Buildings and Fixtures	8,531,552	2,571,863	3.00
4.00	Building Improvements	3,527,295	791,602	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	13,081,025	4,873,545	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	25,948,981	8,495,474	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	25,948,981	8,495,474	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1306 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-7 Part II | Date/Time Prepared: 5/30/2023 10:40 am

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

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

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1306 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-7 Part III | Date/Time Prepared: 5/30/2023 10:40 am

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	12,867,957	0	12,867,957	0.495894	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	13,081,025	0	13,081,025	0.504106	0	2.00
3.00	Total (sum of lines 1-2)	25,948,982	0	25,948,982	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	565,152	-31,301	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	830,368	4,046	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,395,520	-27,255	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	18,753	7,166	0	559,770	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	1,315	0	0	835,729	2.00
3.00	Total (sum of lines 1-2)	0	20,068	7,166	0	1,395,499	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1306 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-8 | Date/Time Prepared: 5/30/2023 10:40 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-149,202	CAP REL COSTS-BLDG & FIXT	1.00	10	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-2,227,509			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	4,457,742			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	0	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	A	0	CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00	MISCELLANEOUS INCOME	B	9,642	ADMINISTRATIVE & GENERAL	5.00	0	33.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1306 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-8 | Date/Time Prepared: 5/30/2023 10:40 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.01	MISCELLANEOUS INCOME	B	-317,646	PHARMACY	15.00	0	33.01
33.02	MISCELLANEOUS INCOME	B	-4,508	RURAL HEALTH CLINIC	88.00	0	33.02
33.03	HAF	A	-1,199,502	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04	BENEFITS	A	-1,994,265	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.04
33.05	CRNA	A	-318,293	NONPHYSICIAN ANESTHETISTS	19.00	0	33.05
33.06	MARKETING	A	-101	ADULTS & PEDIATRICS	30.00	0	33.06
33.07	MARKETING	A	-1,052	RURAL HEALTH CLINIC	88.00	0	33.07
33.08	CLINIC START UP AMORTIZIATION	A	41,430	RURAL HEALTH CLINIC	88.00	0	33.08
33.09	MEDICAL DIRECTOR FEE	A	18,750	LABORATORY	60.00	0	33.09
33.10	CONTRIBUTION EXPENSE	A	-80	ADMINISTRATIVE & GENERAL	5.00	0	33.10
33.11	CONTRIBUTION EXPENSE	A	-443	RADIOLOGY-DIAGNOSTIC	54.00	0	33.11
33.12	RHC PHYSICIAN FEE	A	6,097	RURAL HEALTH CLINIC	88.00	0	33.12
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-1,678,940				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: 15-1306 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-8-1 | Date/Time Prepared: 5/30/2023 10:40 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 ALLOCATION	149,202	0	1.00
2.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE ALLOCATION	1,627,581	0	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE ALLOCATION	4,543,183	4,624,519	3.00
3.01	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE ALLOCATION	226,088	0	3.01
3.03	4.00	EMPLOYEE BENEFITS DEPARTMENT	RELATED PARTY	61,867	40,196	3.03
3.04	5.00	ADMINISTRATIVE & GENERAL	RELATED PARTY	897,089	382,498	3.04
3.05	7.00	OPERATION OF PLANT	RELATED PARTY	27,760	0	3.05
3.06	13.00	NURSING ADMINISTRATION	RELATED PARTY	90,857	30,630	3.06
3.07	15.00	PHARMACY	RELATED PARTY	233,134	120,940	3.07
3.08	54.00	RADIOLOGY-DIAGNOSTIC	RELATED PARTY	55,202	0	3.08
3.09	66.00	PHYSICAL THERAPY	RELATED PARTY	86,396	157,367	3.09
3.10	91.00	EMERGENCY	SIP ER ALLOCATION	2,909,283	1,093,750	3.10
3.11	4.00	EMPLOYEE BENEFITS DEPARTMENT	SHARED EMPLOYEES	1,918	1,918	3.11
3.12	5.00	ADMINISTRATIVE & GENERAL	SHARED EMPLOYEES	11,425	11,425	3.12
3.13	10.00	DIETARY	SHARED EMPLOYEES	4,063	4,063	3.13
3.14	15.00	PHARMACY	SHARED EMPLOYEES	-594	-594	3.14
3.15	30.00	ADULTS & PEDIATRICS	SHARED EMPLOYEES	44,612	44,612	3.15
3.16	60.00	LABORATORY	SHARED EMPLOYEES	2,307,548	2,307,548	3.16
4.00	65.00	RESPIRATORY THERAPY	SHARED EMPLOYEES	800	800	4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			13,277,414	8,819,672	5.00

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

				Related Organization(s) and/or Home Office		
	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	
	1.00	2.00	3.00	4.00	5.00	
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:					
6.00	B		0.00	IU HEALTH BLOOM	0.00	6.00
7.00	B		0.00	IU HEALTH	100.00	7.00
8.00	C		0.00	IUH SIP	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

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.

(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: 15-1306	Period: From 01/01/2022 To 12/31/2022	Worksheet A-8-1 Date/Time Prepared: 5/30/2023 10:40 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	149,202	9		1.00
2.00	1,627,581	9		2.00
3.00	-81,336	0		3.00
3.01	226,088	0		3.01
3.03	21,671	0		3.03
3.04	514,591	0		3.04
3.05	27,760	0		3.05
3.06	60,227	0		3.06
3.07	112,194	0		3.07
3.08	55,202	0		3.08
3.09	-70,971	0		3.09
3.10	1,815,533	0		3.10
3.11	0	0		3.11
3.12	0	0		3.12
3.13	0	0		3.13
3.14	0	0		3.14
3.15	0	0		3.15
3.16	0	0		3.16
4.00	0	0		4.00
5.00	4,457,742			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	HOSPITAL		6.00
7.00	HOME OFFICE		7.00
8.00	PHYSICIAN GROUP		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: 15-1306 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-8-2 | Date/Time Prepared: 5/30/2023 10:40 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	5.00	ADMINISTRATIVE & GENERAL	1,773	1,773	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	637,820	637,820	0	0	0	2.00
3.00	90.01	VISITING SPECIALTY CLINIC	9,818	9,818	0	0	0	3.00
4.00	91.00	EMERGENCY	2,671,848	1,578,098	1,093,750	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			3,321,259	2,227,509	1,093,750		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	90.01	VISITING SPECIALTY CLINIC	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	5.00	ADMINISTRATIVE & GENERAL	0	0	0	1,773		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	637,820		2.00
3.00	90.01	VISITING SPECIALTY CLINIC	0	0	0	9,818		3.00
4.00	91.00	EMERGENCY	0	0	0	1,578,098		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	2,227,509		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1306 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part I Date/Time Prepared: 5/30/2023 10:40 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	559,770	559,770				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	835,729		835,729			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,744,203	4,127	6,507	1,754,837		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	6,671,790	30,562	48,188	95,340	6,845,880	5.00
7.00	00700	OPERATION OF PLANT	1,135,562	38,994	61,483	69,711	1,305,750	7.00
7.01	00701	UTILITIES	472,745	0	0	0	472,745	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	99,669	2,668	4,207	0	106,544	8.00
9.00	00900	HOUSEKEEPING	534,870	7,881	12,426	39,502	594,679	9.00
10.00	01000	DIETARY	262,398	15,930	25,118	17,487	320,933	10.00
11.00	01100	CAFETERIA	195,343	8,583	13,534	13,424	230,884	11.00
13.00	01300	NURSING ADMINISTRATION	1,056,259	19,755	31,148	148,833	1,255,995	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	189,790	18,234	28,750	0	236,774	14.00
15.00	01500	PHARMACY	354,427	10,398	16,395	52,395	433,615	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	6,698	10,560	0	17,258	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	356,557	0	0	59,021	415,578	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,208,041	64,496	101,692	277,219	2,651,448	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	67,351	2,224	3,506	7,263	80,344	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	911,668	53,608	84,525	93,183	1,142,984	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	310,330	5,052	7,966	33,464	356,812	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,588,358	53,244	83,950	159,775	1,885,327	54.00
60.00	06000	LABORATORY	2,605,495	17,033	26,857	0	2,649,385	60.00
64.00	06400	INTRAVENOUS THERAPY	164,115	9,179	14,473	21,313	209,080	64.00
65.00	06500	RESPIRATORY THERAPY	572,192	5,008	7,896	72,896	657,992	65.00
66.00	06600	PHYSICAL THERAPY	506,976	34,414	54,260	68,938	664,588	66.00
67.00	06700	OCCUPATIONAL THERAPY	161,847	9,633	15,188	19,305	205,973	67.00
68.00	06800	SPEECH PATHOLOGY	84,355	5,026	7,924	10,062	107,367	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	82,450	0	0	0	82,450	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	9,747	0	0	0	9,747	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,166,047	0	0	0	2,166,047	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	993,296	44,456	69,673	137,225	1,244,650	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	88,627	338	533	13,446	102,944	90.00
90.01	09001	VISITING SPECIALTY CLINIC	305,765	26,168	41,260	41,593	414,786	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	3,751,021	36,602	57,710	303,442	4,148,775	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	31,046,793	530,311	835,729	1,754,837	31,017,334	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	VISITING SPECIALTY CLINIC	0	0	0	0	0	190.01
190.02	19002	OUTREACH	0	4,269	0	0	4,269	190.02
190.03	19003	FOUNDATION	0	0	0	0	0	190.03
190.04	19004	SPRING VALLEY FAMILY PRACTICE	0	0	0	0	0	190.04
190.05	19005	PAOLI FAMILY PRACTICE	4,970	0	0	0	4,970	190.05
190.06	19006	OTHER PROPERTY	0	25,190	0	0	25,190	190.06
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
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)	31,051,763	559,770	835,729	1,754,837	31,051,763	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1306 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part I Date/Time Prepared: 5/30/2023 10:40 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	UTILITIES	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	7.00	7.01	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	6,845,880					5.00
7.00	00700	OPERATION OF PLANT	369,291	1,675,041				7.00
7.01	00701	UTILITIES	133,701	0	606,446			7.01
8.00	00800	LAUNDRY & LINEN SERVICE	30,133	11,090	3,360	151,127		8.00
9.00	00900	HOUSEKEEPING	168,187	32,751	9,925	0	805,542	9.00
10.00	01000	DIETARY	90,766	66,205	20,062	0	30,449	10.00
11.00	01100	CAFETERIA	65,298	35,671	10,810	0	16,406	11.00
13.00	01300	NURSING ADMINISTRATION	355,219	57,148	24,879	0	37,759	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	66,964	75,779	22,963	0	0	14.00
15.00	01500	PHARMACY	122,635	43,212	13,095	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,881	27,835	8,435	0	12,802	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	117,533	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	749,880	268,035	81,223	132,731	123,274	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	22,723	9,241	2,800	18,396	4,250	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	323,258	222,789	67,512	0	102,465	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	100,913	20,996	6,363	0	9,657	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	533,206	221,274	67,053	0	101,768	54.00
60.00	06000	LABORATORY	749,296	70,788	21,451	0	32,557	60.00
64.00	06400	INTRAVENOUS THERAPY	59,132	38,148	11,560	0	17,545	64.00
65.00	06500	RESPIRATORY THERAPY	186,093	20,811	6,307	0	9,572	65.00
66.00	06600	PHYSICAL THERAPY	187,958	5,175	43,339	0	65,777	66.00
67.00	06700	OCCUPATIONAL THERAPY	58,253	1,442	12,131	0	18,412	67.00
68.00	06800	SPEECH PATHOLOGY	30,365	739	6,329	0	9,606	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	23,318	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,757	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	612,599	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	352,011	183,643	55,650	0	84,461	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	29,115	1,405	426	0	646	90.00
90.01	09001	VISITING SPECIALTY CLINIC	117,309	108,752	32,955	0	50,017	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	1,173,349	152,112	46,095	0	69,959	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	6,836,143	1,675,041	574,723	151,127	797,382	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	VISITING SPECIALTY CLINIC	0	0	0	0	0	190.01
190.02	19002	OUTREACH	1,207	0	0	0	8,160	190.02
190.03	19003	FOUNDATION	0	0	0	0	0	190.03
190.04	19004	SPRING VALLEY FAMILY PRACTICE	0	0	0	0	0	190.04
190.05	19005	PAOLI FAMILY PRACTICE	1,406	0	0	0	0	190.05
190.06	19006	OTHER PROPERTY	7,124	0	31,723	0	0	190.06
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	6,845,880	1,675,041	606,446	151,127	805,542	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1306 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part I | Date/Time Prepared: 5/30/2023 10:40 am

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	UTILITIES						7.01
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	528,415					10.00
11.00	01100	CAFETERIA	0	359,069				11.00
13.00	01300	NURSING ADMINISTRATION	0	33,137	1,764,137			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	402,480		14.00
15.00	01500	PHARMACY	0	14,671	0	2,745	629,973	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	6,851	0	1,987	8	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	528,415	49,452	551,134	44,605	4,440	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	0	1,645	20,508	37,036	275	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	18,572	201,252	34,504	1,703	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	7,576	94,480	1,726	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	42,155	37,119	3,147	2,211	54.00
60.00	06000	LABORATORY	0	32,913	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	4,751	63,407	10,065	1,625	64.00
65.00	06500	RESPIRATORY THERAPY	0	14,354	0	27,671	0	65.00
66.00	06600	PHYSICAL THERAPY	0	20,172	0	435	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	3,510	0	122	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	2,954	0	64	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	107,719	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	12,735	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	603,179	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	36,448	122,275	12,920	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	1,575	0	0	0	90.00
90.01	09001	VISITING SPECIALTY CLINIC	0	16,866	72,067	2,583	0	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	0	51,467	601,895	102,416	16,532	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	528,415	359,069	1,764,137	402,480	629,973	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	VISITING SPECIALTY CLINIC	0	0	0	0	0	190.01
190.02	19002	OUTREACH	0	0	0	0	0	190.02
190.03	19003	FOUNDATION	0	0	0	0	0	190.03
190.04	19004	SPRING VALLEY FAMILY PRACTICE	0	0	0	0	0	190.04
190.05	19005	PAOLI FAMILY PRACTICE	0	0	0	0	0	190.05
190.06	19006	OTHER PROPERTY	0	0	0	0	0	190.06
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	528,415	359,069	1,764,137	402,480	629,973	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1306 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part I Date/Time Prepared: 5/30/2023 10:40 am

		Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			16.00	17.00	19.00	24.00	25.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	UTILITIES						7.01
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	71,211					16.00
17.00	01700	SOCIAL SERVICE	0	0				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	541,957			19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,468	0	0	5,190,105	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	210	0	0	197,428	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,991	0	541,957	2,661,987	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	699	0	0	599,222	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	13,215	0	0	2,906,475	0	54.00
60.00	06000	LABORATORY	7,456	0	0	3,563,846	0	60.00
64.00	06400	INTRAVENOUS THERAPY	1,664	0	0	416,977	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,195	0	0	923,995	0	65.00
66.00	06600	PHYSICAL THERAPY	1,392	0	0	988,836	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	538	0	0	300,381	0	67.00
68.00	06800	SPEECH PATHOLOGY	102	0	0	157,526	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	71	0	0	213,558	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	122	0	0	25,361	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	11,186	0	0	3,393,011	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,101	0	0	2,093,159	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	67	0	0	136,178	0	90.00
90.01	09001	VISITING SPECIALTY CLINIC	798	0	0	816,133	0	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	20,936	0	0	6,383,536	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	71,211	0	541,957	30,967,714	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	VISITING SPECIALTY CLINIC	0	0	0	0	0	190.01
190.02	19002	OUTREACH	0	0	0	13,636	0	190.02
190.03	19003	FOUNDATION	0	0	0	0	0	190.03
190.04	19004	SPRING VALLEY FAMILY PRACTICE	0	0	0	0	0	190.04
190.05	19005	PAOLI FAMILY PRACTICE	0	0	0	6,376	0	190.05
190.06	19006	OTHER PROPERTY	0	0	0	64,037	0	190.06
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	71,211	0	541,957	31,051,763	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1306 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part I | Date/Time Prepared: 5/30/2023 10:40 am

		Cost Center Description	Total		
			26.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
7.00	00700	OPERATION OF PLANT			7.00
7.01	00701	UTILITIES			7.01
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS			19.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	5,190,105		30.00
31.00	03100	INTENSIVE CARE UNIT	0		31.00
43.00	04300	NURSERY	197,428		43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	2,661,987		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	599,222		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,906,475		54.00
60.00	06000	LABORATORY	3,563,846		60.00
64.00	06400	INTRAVENOUS THERAPY	416,977		64.00
65.00	06500	RESPIRATORY THERAPY	923,995		65.00
66.00	06600	PHYSICAL THERAPY	988,836		66.00
67.00	06700	OCCUPATIONAL THERAPY	300,381		67.00
68.00	06800	SPEECH PATHOLOGY	157,526		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	213,558		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	25,361		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,393,011		73.00
74.00	07400	RENAL DIALYSIS	0		74.00
75.00	07500	ASC (NON-DISTINCT PART)	0		75.00
76.97	07697	CARDIAC REHABILITATION	0		76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0		77.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	2,093,159		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		89.00
90.00	09000	CLINIC	136,178		90.00
90.01	09001	VISITING SPECIALTY CLINIC	816,133		90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0		90.02
91.00	09100	EMERGENCY	6,383,536		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0		95.00
101.00	10100	HOME HEALTH AGENCY	0		101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0		102.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	30,967,714		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		190.00
190.01	19001	VISITING SPECIALTY CLINIC	0		190.01
190.02	19002	OUTREACH	13,636		190.02
190.03	19003	FOUNDATION	0		190.03
190.04	19004	SPRING VALLEY FAMILY PRACTICE	0		190.04
190.05	19005	PAOLI FAMILY PRACTICE	6,376		190.05
190.06	19006	OTHER PROPERTY	64,037		190.06
191.00	19100	RESEARCH	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0		192.00
193.00	19300	NONPAID WORKERS	0		193.00
200.00		Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118 through 201)	31,051,763		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1306 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part II Date/Time Prepared: 5/30/2023 10:40 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	4,127	6,507	10,634	10,634	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	226,088	30,562	48,188	304,838	578	5.00
7.00	00700	OPERATION OF PLANT	0	38,994	61,483	100,477	423	7.00
7.01	00701	UTILITIES	0	0	0	0	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	2,668	4,207	6,875	0	8.00
9.00	00900	HOUSEKEEPING	0	7,881	12,426	20,307	239	9.00
10.00	01000	DIETARY	0	15,930	25,118	41,048	106	10.00
11.00	01100	CAFETERIA	0	8,583	13,534	22,117	81	11.00
13.00	01300	NURSING ADMINISTRATION	0	19,755	31,148	50,903	902	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	18,234	28,750	46,984	0	14.00
15.00	01500	PHARMACY	0	10,398	16,395	26,793	318	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	6,698	10,560	17,258	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	358	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	64,496	101,692	166,188	1,680	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	0	2,224	3,506	5,730	44	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	53,608	84,525	138,133	565	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	5,052	7,966	13,018	203	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	53,244	83,950	137,194	968	54.00
60.00	06000	LABORATORY	0	17,033	26,857	43,890	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	9,179	14,473	23,652	129	64.00
65.00	06500	RESPIRATORY THERAPY	0	5,008	7,896	12,904	442	65.00
66.00	06600	PHYSICAL THERAPY	0	34,414	54,260	88,674	418	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	9,633	15,188	24,821	117	67.00
68.00	06800	SPEECH PATHOLOGY	0	5,026	7,924	12,950	61	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	44,456	69,673	114,129	832	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	338	533	871	82	90.00
90.01	09001	VISITING SPECIALTY CLINIC	0	26,168	41,260	67,428	252	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	0	36,602	57,710	94,312	1,836	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	226,088	530,311	835,729	1,592,128	10,634	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	VISITING SPECIALTY CLINIC	0	0	0	0	0	190.01
190.02	19002	OUTREACH	0	4,269	0	4,269	0	190.02
190.03	19003	FOUNDATION	0	0	0	0	0	190.03
190.04	19004	SPRING VALLEY FAMILY PRACTICE	0	0	0	0	0	190.04
190.05	19005	PAOLI FAMILY PRACTICE	0	0	0	0	0	190.05
190.06	19006	OTHER PROPERTY	0	25,190	0	25,190	0	190.06
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
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)	226,088	559,770	835,729	1,621,587	10,634	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1306 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part II Date/Time Prepared: 5/30/2023 10:40 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	UTILITIES	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	7.00	7.01	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	305,416					5.00
7.00	00700	OPERATION OF PLANT	16,475	117,375				7.00
7.01	00701	UTILITIES	5,965	0	5,965			7.01
8.00	00800	LAUNDRY & LINEN SERVICE	1,344	777	33	9,029		8.00
9.00	00900	HOUSEKEEPING	7,503	2,295	98	0	30,442	9.00
10.00	01000	DIETARY	4,049	4,639	197	0	1,151	10.00
11.00	01100	CAFETERIA	2,913	2,500	106	0	620	11.00
13.00	01300	NURSING ADMINISTRATION	15,847	4,005	245	0	1,427	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,987	5,310	226	0	0	14.00
15.00	01500	PHARMACY	5,471	3,028	129	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	218	1,950	83	0	484	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	5,243	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	33,453	18,783	799	7,930	4,658	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	1,014	648	28	1,099	161	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	14,421	15,611	664	0	3,872	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,502	1,471	63	0	365	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	23,787	15,505	660	0	3,846	54.00
60.00	06000	LABORATORY	33,427	4,960	211	0	1,230	60.00
64.00	06400	INTRAVENOUS THERAPY	2,638	2,673	114	0	663	64.00
65.00	06500	RESPIRATORY THERAPY	8,302	1,458	62	0	362	65.00
66.00	06600	PHYSICAL THERAPY	8,385	363	426	0	2,486	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,599	101	119	0	696	67.00
68.00	06800	SPEECH PATHOLOGY	1,355	52	62	0	363	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,040	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	123	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	27,329	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	15,704	12,868	547	0	3,192	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	1,299	98	4	0	24	90.00
90.01	09001	VISITING SPECIALTY CLINIC	5,233	7,621	324	0	1,890	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	52,355	10,659	453	0	2,644	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	304,981	117,375	5,653	9,029	30,134	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	VISITING SPECIALTY CLINIC	0	0	0	0	0	190.01
190.02	19002	OUTREACH	54	0	0	0	308	190.02
190.03	19003	FOUNDATION	0	0	0	0	0	190.03
190.04	19004	SPRING VALLEY FAMILY PRACTICE	0	0	0	0	0	190.04
190.05	19005	PAOLI FAMILY PRACTICE	63	0	0	0	0	190.05
190.06	19006	OTHER PROPERTY	318	0	312	0	0	190.06
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	305,416	117,375	5,965	9,029	30,442	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1306 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part II | Date/Time Prepared: 5/30/2023 10:40 am

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	UTILITIES						7.01
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	51,190					10.00
11.00	01100	CAFETERIA	0	28,337				11.00
13.00	01300	NURSING ADMINISTRATION	0	2,615	75,944			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	55,507		14.00
15.00	01500	PHARMACY	0	1,158	0	379	37,276	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	541	0	274	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	51,190	3,903	23,726	6,152	263	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	0	130	883	5,108	16	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,466	8,664	4,759	101	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	598	4,067	238	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,327	1,598	434	131	54.00
60.00	06000	LABORATORY	0	2,597	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	375	2,730	1,388	96	64.00
65.00	06500	RESPIRATORY THERAPY	0	1,133	0	3,816	0	65.00
66.00	06600	PHYSICAL THERAPY	0	1,592	0	60	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	277	0	17	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	233	0	9	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	14,855	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,756	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	35,691	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	2,876	5,264	1,782	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	124	0	0	0	90.00
90.01	09001	VISITING SPECIALTY CLINIC	0	1,331	3,102	356	0	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	0	4,061	25,910	14,124	978	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	51,190	28,337	75,944	55,507	37,276	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	VISITING SPECIALTY CLINIC	0	0	0	0	0	190.01
190.02	19002	OUTREACH	0	0	0	0	0	190.02
190.03	19003	FOUNDATION	0	0	0	0	0	190.03
190.04	19004	SPRING VALLEY FAMILY PRACTICE	0	0	0	0	0	190.04
190.05	19005	PAOLI FAMILY PRACTICE	0	0	0	0	0	190.05
190.06	19006	OTHER PROPERTY	0	0	0	0	0	190.06
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	51,190	28,337	75,944	55,507	37,276	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1306 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part II Date/Time Prepared: 5/30/2023 10:40 am

		Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			16.00	17.00	19.00	24.00	25.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	UTILITIES						7.01
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	19,993					16.00
17.00	01700	SOCIAL SERVICE	0	0				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	6,416			19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,536	0		320,261	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0		0	0	31.00
43.00	04300	NURSERY	59	0		14,920	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,402	0		189,658	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	196	0		24,721	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,711	0		191,161	0	54.00
60.00	06000	LABORATORY	2,094	0		88,409	0	60.00
64.00	06400	INTRAVENOUS THERAPY	467	0		34,925	0	64.00
65.00	06500	RESPIRATORY THERAPY	336	0		28,815	0	65.00
66.00	06600	PHYSICAL THERAPY	391	0		102,795	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	151	0		28,898	0	67.00
68.00	06800	SPEECH PATHOLOGY	29	0		15,114	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	20	0		15,915	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	34	0		1,913	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,141	0		66,161	0	73.00
74.00	07400	RENAL DIALYSIS	0	0		0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0		0	0	75.00
76.97	07697	CARDIAC REHABILITATION	0	0		0	0	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0		0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	309	0		157,503	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0		0	0	89.00
90.00	09000	CLINIC	19	0		2,521	0	90.00
90.01	09001	VISITING SPECIALTY CLINIC	224	0		87,761	0	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0	0		0	0	90.02
91.00	09100	EMERGENCY	5,874	0		213,206	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0		0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0		0	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0		0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	19,993	0	0	1,584,657	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0	0	190.00
190.01	19001	VISITING SPECIALTY CLINIC	0	0		0	0	190.01
190.02	19002	OUTREACH	0	0		4,631	0	190.02
190.03	19003	FOUNDATION	0	0		0	0	190.03
190.04	19004	SPRING VALLEY FAMILY PRACTICE	0	0		0	0	190.04
190.05	19005	PAOLI FAMILY PRACTICE	0	0		63	0	190.05
190.06	19006	OTHER PROPERTY	0	0		25,820	0	190.06
191.00	19100	RESEARCH	0	0		0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		0	0	192.00
193.00	19300	NONPAID WORKERS	0	0		0	0	193.00
200.00		Cross Foot Adjustments			6,416	6,416	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	19,993	0	6,416	1,621,587	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1306 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part II Date/Time Prepared: 5/30/2023 10:40 am

		Cost Center Description	Total		
			26.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
7.00	00700	OPERATION OF PLANT			7.00
7.01	00701	UTILITIES			7.01
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS			19.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	320,261		30.00
31.00	03100	INTENSIVE CARE UNIT	0		31.00
43.00	04300	NURSERY	14,920		43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	189,658		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	24,721		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	191,161		54.00
60.00	06000	LABORATORY	88,409		60.00
64.00	06400	INTRAVENOUS THERAPY	34,925		64.00
65.00	06500	RESPIRATORY THERAPY	28,815		65.00
66.00	06600	PHYSICAL THERAPY	102,795		66.00
67.00	06700	OCCUPATIONAL THERAPY	28,898		67.00
68.00	06800	SPEECH PATHOLOGY	15,114		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	15,915		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,913		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	66,161		73.00
74.00	07400	RENAL DIALYSIS	0		74.00
75.00	07500	ASC (NON-DISTINCT PART)	0		75.00
76.97	07697	CARDIAC REHABILITATION	0		76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0		77.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	157,503		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		89.00
90.00	09000	CLINIC	2,521		90.00
90.01	09001	VISITING SPECIALTY CLINIC	87,761		90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0		90.02
91.00	09100	EMERGENCY	213,206		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0		95.00
101.00	10100	HOME HEALTH AGENCY	0		101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0		102.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,584,657		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		190.00
190.01	19001	VISITING SPECIALTY CLINIC	0		190.01
190.02	19002	OUTREACH	4,631		190.02
190.03	19003	FOUNDATION	0		190.03
190.04	19004	SPRING VALLEY FAMILY PRACTICE	0		190.04
190.05	19005	PAOLI FAMILY PRACTICE	63		190.05
190.06	19006	OTHER PROPERTY	25,820		190.06
191.00	19100	RESEARCH	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0		192.00
193.00	19300	NONPAID WORKERS	0		193.00
200.00		Cross Foot Adjustments	6,416		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118 through 201)	1,621,587		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1306 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B-1 | Date/Time Prepared: 5/30/2023 10:40 am

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	62,933					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		59,591				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	464	464	10,766,103			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,436	3,436	584,925	-6,845,880	24,205,883	5.00
7.00	00700	OPERATION OF PLANT	4,384	4,384	427,686	0	1,305,750	7.00
7.01	00701	UTILITIES	0	0	0	0	472,745	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	300	300	0	0	106,544	8.00
9.00	00900	HOUSEKEEPING	886	886	242,351	0	594,679	9.00
10.00	01000	DIETARY	1,791	1,791	107,282	0	320,933	10.00
11.00	01100	CAFETERIA	965	965	82,360	0	230,884	11.00
13.00	01300	NURSING ADMINISTRATION	2,221	2,221	913,109	0	1,255,995	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,050	2,050	0	0	236,774	14.00
15.00	01500	PHARMACY	1,169	1,169	321,448	0	433,615	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	753	753	0	0	17,258	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	362,101	0	415,578	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,251	7,251	1,700,772	0	2,651,448	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	250	250	44,557	0	80,344	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,027	6,027	571,690	0	1,142,984	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	568	568	205,303	0	356,812	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,986	5,986	980,236	0	1,885,327	54.00
60.00	06000	LABORATORY	1,915	1,915	0	0	2,649,385	60.00
64.00	06400	INTRAVENOUS THERAPY	1,032	1,032	130,756	0	209,080	64.00
65.00	06500	RESPIRATORY THERAPY	563	563	447,224	0	657,992	65.00
66.00	06600	PHYSICAL THERAPY	3,869	3,869	422,942	0	664,588	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,083	1,083	118,440	0	205,973	67.00
68.00	06800	SPEECH PATHOLOGY	565	565	61,731	0	107,367	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	82,450	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	9,747	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	2,166,047	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	4,998	4,968	841,889	0	1,244,650	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	38	38	82,495	0	102,944	90.00
90.01	09001	VISITING SPECIALTY CLINIC	2,942	2,942	255,178	0	414,786	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	4,115	4,115	1,861,628	0	4,148,775	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	59,621	59,591	10,766,103	-6,845,880	24,171,454	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	VISITING SPECIALTY CLINIC	0	0	0	0	0	190.01
190.02	19002	OUTREACH	480	0	0	0	4,269	190.02
190.03	19003	FOUNDATION	0	0	0	0	0	190.03
190.04	19004	SPRING VALLEY FAMILY PRACTICE	0	0	0	0	0	190.04
190.05	19005	PAOLI FAMILY PRACTICE	0	0	0	0	4,970	190.05
190.06	19006	OTHER PROPERTY	2,832	0	0	0	25,190	190.06
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
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)	559,770	835,729	1,754,837		6,845,880	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	8.894698	14.024416	0.162996		0.282819	203.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1306 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B-1 | Date/Time Prepared: 5/30/2023 10:40 am

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
204.00		Cost to be allocated (per Wkst. B, Part II)			10,634		305,416	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000988		0.012617	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: 15-1306 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B-1 | Date/Time Prepared: 5/30/2023 10:40 am

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	UTILITIES (SQUARE FEET)	LAUNDRY & LINEN SERVICE (TOTAL PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
			7.00	7.01	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	45,314					7.00
7.01	00701	UTILITIES	0	54,139				7.01
8.00	00800	LAUNDRY & LINEN SERVICE	300	300	1,528			8.00
9.00	00900	HOUSEKEEPING	886	886	0	47,382		9.00
10.00	01000	DIETARY	1,791	1,791	0	1,791	7,527	10.00
11.00	01100	CAFETERIA	965	965	0	965	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,546	2,221	0	2,221	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,050	2,050	0	0	0	14.00
15.00	01500	PHARMACY	1,169	1,169	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	753	753	0	753	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,251	7,251	1,342	7,251	7,527	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	250	250	186	250	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,027	6,027	0	6,027	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	568	568	0	568	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,986	5,986	0	5,986	0	54.00
60.00	06000	LABORATORY	1,915	1,915	0	1,915	0	60.00
64.00	06400	INTRAVENOUS THERAPY	1,032	1,032	0	1,032	0	64.00
65.00	06500	RESPIRATORY THERAPY	563	563	0	563	0	65.00
66.00	06600	PHYSICAL THERAPY	140	3,869	0	3,869	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	39	1,083	0	1,083	0	67.00
68.00	06800	SPEECH PATHOLOGY	20	565	0	565	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	4,968	4,968	0	4,968	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	38	38	0	38	0	90.00
90.01	09001	VISITING SPECIALTY CLINIC	2,942	2,942	0	2,942	0	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	4,115	4,115	0	4,115	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	45,314	51,307	1,528	46,902	7,527	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	VISITING SPECIALTY CLINIC	0	0	0	0	0	190.01
190.02	19002	OUTREACH	0	0	0	480	0	190.02
190.03	19003	FOUNDATION	0	0	0	0	0	190.03
190.04	19004	SPRING VALLEY FAMILY PRACTICE	0	0	0	0	0	190.04
190.05	19005	PAOLI FAMILY PRACTICE	0	0	0	0	0	190.05
190.06	19006	OTHER PROPERTY	0	2,832	0	0	0	190.06
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
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)	1,675,041	606,446	151,127	805,542	528,415	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	36.965198	11.201648	98.905105	17.001013	70.202604	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	117,375	5,965	9,029	30,442	51,190	204.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1306 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B-1 | Date/Time Prepared: 5/30/2023 10:40 am

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	UTILITIES (SQUARE FEET)	LAUNDRY & LINEN SERVICE (TOTAL PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
			7.00	7.01	8.00	9.00	10.00	
205.00		Unit cost multiplier (Wkst. B, Part II)	2.590259	0.110179	5.909031	0.642480	6.800850	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: 15-1306 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B-1 | Date/Time Prepared: 5/30/2023 10:40 am

		Cost Center Description	CAFETERIA (MAN HOURS)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	UTILITIES						7.01
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	216,360					11.00
13.00	01300	NURSING ADMINISTRATION	19,967	79,655				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	308,054			14.00
15.00	01500	PHARMACY	8,840	0	2,101	2,262,266		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	90,485,812	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	4,128	0	1,521	29	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	29,798	24,885	34,140	15,946	6,948,081	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	991	926	28,347	987	266,647	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	11,191	9,087	26,409	6,114	6,342,158	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,565	4,266	1,321	0	888,596	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	25,401	1,676	2,409	7,941	16,791,108	54.00
60.00	06000	LABORATORY	19,832	0	0	0	9,474,543	60.00
64.00	06400	INTRAVENOUS THERAPY	2,863	2,863	7,704	5,835	2,114,904	64.00
65.00	06500	RESPIRATORY THERAPY	8,649	0	21,179	0	1,518,293	65.00
66.00	06600	PHYSICAL THERAPY	12,155	0	333	0	1,769,325	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,115	0	93	0	683,522	67.00
68.00	06800	SPEECH PATHOLOGY	1,780	0	49	0	129,328	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	82,447	0	90,551	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	9,747	0	155,043	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	2,166,047	14,212,859	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	21,962	5,521	9,889	0	1,398,870	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	949	0	0	0	84,919	90.00
90.01	09001	VISITING SPECIALTY CLINIC	10,163	3,254	1,977	1	1,014,122	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	31,011	27,177	78,388	59,366	26,602,943	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	216,360	79,655	308,054	2,262,266	90,485,812	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	VISITING SPECIALTY CLINIC	0	0	0	0	0	190.01
190.02	19002	OUTREACH	0	0	0	0	0	190.02
190.03	19003	FOUNDATION	0	0	0	0	0	190.03
190.04	19004	SPRING VALLEY FAMILY PRACTICE	0	0	0	0	0	190.04
190.05	19005	PAOLI FAMILY PRACTICE	0	0	0	0	0	190.05
190.06	19006	OTHER PROPERTY	0	0	0	0	0	190.06
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
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)	359,069	1,764,137	402,480	629,973	71,211	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	1.659590	22.147222	1.306524	0.278470	0.000787	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	28,337	75,944	55,507	37,276	19,993	204.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1306 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B-1 | Date/Time Prepared: 5/30/2023 10:40 am

		Cost Center Description	CAFETERIA (MAN HOURS)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
			11.00	13.00	14.00	15.00	16.00	
205.00		Unit cost multiplier (Wkst. B, Part II)	0.130972	0.953412	0.180186	0.016477	0.000221	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: 15-1306 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B-1 | Date/Time Prepared: 5/30/2023 10:40 am

		Cost Center Description	SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)		
			17.00	19.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
7.01	00701	UTILITIES				7.01
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE	0			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	100		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	0		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0		31.00
43.00	04300	NURSERY	0	0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	100		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0		75.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0		77.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
90.00	09000	CLINIC	0	0		90.00
90.01	09001	VISITING SPECIALTY CLINIC	0	0		90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0	0		90.02
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	0		95.00
101.00	10100	HOME HEALTH AGENCY	0	0		101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0		102.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	100		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
190.01	19001	VISITING SPECIALTY CLINIC	0	0		190.01
190.02	19002	OUTREACH	0	0		190.02
190.03	19003	FOUNDATION	0	0		190.03
190.04	19004	SPRING VALLEY FAMILY PRACTICE	0	0		190.04
190.05	19005	PAOLI FAMILY PRACTICE	0	0		190.05
190.06	19006	OTHER PROPERTY	0	0		190.06
191.00	19100	RESEARCH	0	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
193.00	19300	NONPAID WORKERS	0	0		193.00
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)	0	541,957		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	5,419.570000		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	6,416		204.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1306 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B-1 | Date/Time Prepared: 5/30/2023 10:40 am

		Cost Center Description	SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)		
			17.00	19.00		
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	64.160000		205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)				206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)				207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1306 | Period: From 01/01/2022 To 12/31/2022 | Worksheet C Part I Date/Time Prepared: 5/30/2023 10:40 am

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,190,105		5,190,105	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0		0	0	0	31.00
43.00	04300	NURSERY	197,428		197,428	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,661,987		2,661,987	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	599,222		599,222	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,906,475		2,906,475	0	0	54.00
60.00	06000	LABORATORY	3,563,846		3,563,846	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	416,977		416,977	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	923,995	0	923,995	0	0	65.00
66.00	06600	PHYSICAL THERAPY	988,836	0	988,836	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	300,381	0	300,381	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	157,526	0	157,526	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	213,558		213,558	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	25,361		25,361	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,393,011		3,393,011	0	0	73.00
74.00	07400	RENAL DIALYSIS	0		0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0		0	0	0	75.00
76.97	07697	CARDIAC REHABILITATION	0		0	0	0	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0		0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,093,159		2,093,159	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
90.00	09000	CLINIC	136,178		136,178	0	0	90.00
90.01	09001	VISITING SPECIALTY CLINIC	816,133		816,133	0	0	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0		0	0	0	90.02
91.00	09100	EMERGENCY	6,383,536		6,383,536	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,605,476		1,605,476		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0		0		0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	32,573,190	0	32,573,190	0	0	200.00
201.00		Less Observation Beds	1,605,476		1,605,476		0	201.00
202.00		Total (see instructions)	30,967,714	0	30,967,714	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1306 | Period: From 01/01/2022 To 12/31/2022 | Worksheet C Part I Date/Time Prepared: 5/30/2023 10:40 am

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,333,461		3,333,461			30.00
31.00	03100	INTENSIVE CARE UNIT	0		0			31.00
43.00	04300	NURSERY	266,647		266,647			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	816,222	5,525,936	6,342,158	0.419729	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	477,741	410,855	888,596	0.674347	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	461,538	16,329,570	16,791,108	0.173096	0.000000	54.00
60.00	06000	LABORATORY	1,011,227	8,463,316	9,474,543	0.376150	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	2,609	2,112,295	2,114,904	0.197161	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	400,894	1,117,399	1,518,293	0.608575	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	153,486	1,615,839	1,769,325	0.558878	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	115,711	567,811	683,522	0.439461	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	22,933	106,395	129,328	1.218035	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	8,752	81,799	90,551	2.358428	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	155,043	155,043	0.163574	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,717,499	12,495,360	14,212,859	0.238728	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0.000000	0.000000	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0.000000	0.000000	75.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	0.000000	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0.000000	0.000000	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	1,398,870	1,398,870			88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0			89.00
90.00	09000	CLINIC	0	84,919	84,919	1.603622	0.000000	90.00
90.01	09001	VISITING SPECIALTY CLINIC	0	1,014,122	1,014,122	0.804768	0.000000	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0	0	0	0.000000	0.000000	90.02
91.00	09100	EMERGENCY	218,033	26,384,910	26,602,943	0.239956	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	7,905	3,606,715	3,614,620	0.444162	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0			102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	9,014,658	81,471,154	90,485,812			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	9,014,658	81,471,154	90,485,812			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1306 | Period: From 01/01/2022 To 12/31/2022 | Worksheet C Part I Date/Time Prepared: 5/30/2023 10:40 am

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000		64.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
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
74.00	07400	RENAL DIALYSIS	0.000000		74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000		75.00
76.97	07697	CARDIAC REHABILITATION	0.000000		76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000		77.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC			88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER			89.00
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	VISITING SPECIALTY CLINIC	0.000000		90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0.000000		90.02
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
101.00	10100	HOME HEALTH AGENCY			101.00
102.00	10200	OPIOID TREATMENT PROGRAM			102.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
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: 15-1306 | Period: From 01/01/2022 To 12/31/2022 | Worksheet C Part I Date/Time Prepared: 5/30/2023 10:40 am

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,190,105		5,190,105	0	5,190,105	30.00
31.00	03100	INTENSIVE CARE UNIT	0		0	0	0	31.00
43.00	04300	NURSERY	197,428		197,428	0	197,428	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,661,987		2,661,987	0	2,661,987	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	599,222		599,222	0	599,222	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,906,475		2,906,475	0	2,906,475	54.00
60.00	06000	LABORATORY	3,563,846		3,563,846	0	3,563,846	60.00
64.00	06400	INTRAVENOUS THERAPY	416,977		416,977	0	416,977	64.00
65.00	06500	RESPIRATORY THERAPY	923,995	0	923,995	0	923,995	65.00
66.00	06600	PHYSICAL THERAPY	988,836	0	988,836	0	988,836	66.00
67.00	06700	OCCUPATIONAL THERAPY	300,381	0	300,381	0	300,381	67.00
68.00	06800	SPEECH PATHOLOGY	157,526	0	157,526	0	157,526	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	213,558		213,558	0	213,558	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	25,361		25,361	0	25,361	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,393,011		3,393,011	0	3,393,011	73.00
74.00	07400	RENAL DIALYSIS	0		0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0		0	0	0	75.00
76.97	07697	CARDIAC REHABILITATION	0		0	0	0	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0		0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,093,159		2,093,159	0	2,093,159	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
90.00	09000	CLINIC	136,178		136,178	0	136,178	90.00
90.01	09001	VISITING SPECIALTY CLINIC	816,133		816,133	0	816,133	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0		0	0	0	90.02
91.00	09100	EMERGENCY	6,383,536		6,383,536	0	6,383,536	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,605,476		1,605,476		1,605,476	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0		0		0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	32,573,190	0	32,573,190	0	32,573,190	200.00
201.00		Less Observation Beds	1,605,476		1,605,476		1,605,476	201.00
202.00		Total (see instructions)	30,967,714	0	30,967,714	0	30,967,714	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1306 | Period: From 01/01/2022 To 12/31/2022 | Worksheet C Part I Date/Time Prepared: 5/30/2023 10:40 am

Title XIX | Hospital | PPS

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,333,461		3,333,461			30.00
31.00	03100	INTENSIVE CARE UNIT	0		0			31.00
43.00	04300	NURSERY	266,647		266,647			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	816,222	5,525,936	6,342,158	0.419729	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	477,741	410,855	888,596	0.674347	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	461,538	16,329,570	16,791,108	0.173096	0.000000	54.00
60.00	06000	LABORATORY	1,011,227	8,463,316	9,474,543	0.376150	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	2,609	2,112,295	2,114,904	0.197161	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	400,894	1,117,399	1,518,293	0.608575	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	153,486	1,615,839	1,769,325	0.558878	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	115,711	567,811	683,522	0.439461	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	22,933	106,395	129,328	1.218035	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	8,752	81,799	90,551	2.358428	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	155,043	155,043	0.163574	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,717,499	12,495,360	14,212,859	0.238728	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0.000000	0.000000	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0.000000	0.000000	75.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	0.000000	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0.000000	0.000000	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	1,398,870	1,398,870	1.496321	0.000000	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.000000	0.000000	89.00
90.00	09000	CLINIC	0	84,919	84,919	1.603622	0.000000	90.00
90.01	09001	VISITING SPECIALTY CLINIC	0	1,014,122	1,014,122	0.804768	0.000000	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0	0	0	0.000000	0.000000	90.02
91.00	09100	EMERGENCY	218,033	26,384,910	26,602,943	0.239956	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	7,905	3,606,715	3,614,620	0.444162	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0			102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	9,014,658	81,471,154	90,485,812			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	9,014,658	81,471,154	90,485,812			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1306 | Period: From 01/01/2022 To 12/31/2022 | Worksheet C Part I Date/Time Prepared: 5/30/2023 10:40 am

Title XIX | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.419729		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.674347		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.173096		54.00
60.00	06000	LABORATORY	0.376150		60.00
64.00	06400	INTRAVENOUS THERAPY	0.197161		64.00
65.00	06500	RESPIRATORY THERAPY	0.608575		65.00
66.00	06600	PHYSICAL THERAPY	0.558878		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.439461		67.00
68.00	06800	SPEECH PATHOLOGY	1.218035		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2.358428		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.163574		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.238728		73.00
74.00	07400	RENAL DIALYSIS	0.000000		74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000		75.00
76.97	07697	CARDIAC REHABILITATION	0.000000		76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000		77.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	1.496321		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		89.00
90.00	09000	CLINIC	1.603622		90.00
90.01	09001	VISITING SPECIALTY CLINIC	0.804768		90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0.000000		90.02
91.00	09100	EMERGENCY	0.239956		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.444162		92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
101.00	10100	HOME HEALTH AGENCY			101.00
102.00	10200	OPIOID TREATMENT PROGRAM			102.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

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

Provider CCN: 15-1306 | Period: From 01/01/2022 To 12/31/2022 | Worksheet C Part II | Date/Time Prepared: 5/30/2023 10:40 am

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,661,987	189,658	2,472,329	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	599,222	24,721	574,501	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,906,475	191,161	2,715,314	0	0	54.00
60.00	06000	LABORATORY	3,563,846	88,409	3,475,437	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	416,977	34,925	382,052	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	923,995	28,815	895,180	0	0	65.00
66.00	06600	PHYSICAL THERAPY	988,836	102,795	886,041	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	300,381	28,898	271,483	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	157,526	15,114	142,412	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	213,558	15,915	197,643	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	25,361	1,913	23,448	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,393,011	66,161	3,326,850	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,093,159	157,503	1,935,656	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	136,178	2,521	133,657	0	0	90.00
90.01	09001	VISITING SPECIALTY CLINIC	816,133	87,761	728,372	0	0	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	6,383,536	213,206	6,170,330	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,605,476	99,068	1,506,408	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (sum of lines 50 thru 199)	27,185,657	1,348,544	25,837,113	0	0	200.00
201.00		Less Observation Beds	1,605,476	99,068	1,506,408	0	0	201.00
202.00		Total (line 200 minus line 201)	25,580,181	1,249,476	24,330,705	0	0	202.00

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

Provider CCN: 15-1306 | Period: From 01/01/2022 To 12/31/2022 | Worksheet C Part II | Date/Time Prepared: 5/30/2023 10:40 am

Title XIX | Hospital | PPS

		Cost Center Description	Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)		
			6.00	7.00	8.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	2,661,987	6,342,158	0.419729		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	599,222	888,596	0.674347		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,906,475	16,791,108	0.173096		54.00
60.00	06000	LABORATORY	3,563,846	9,474,543	0.376150		60.00
64.00	06400	INTRAVENOUS THERAPY	416,977	2,114,904	0.197161		64.00
65.00	06500	RESPIRATORY THERAPY	923,995	1,518,293	0.608575		65.00
66.00	06600	PHYSICAL THERAPY	988,836	1,769,325	0.558878		66.00
67.00	06700	OCCUPATIONAL THERAPY	300,381	683,522	0.439461		67.00
68.00	06800	SPEECH PATHOLOGY	157,526	129,328	1.218035		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	213,558	90,551	2.358428		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	25,361	155,043	0.163574		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,393,011	14,212,859	0.238728		73.00
74.00	07400	RENAL DIALYSIS	0	0	0.000000		74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0.000000		75.00
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000		76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0.000000		77.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	2,093,159	1,398,870	1.496321		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000		89.00
90.00	09000	CLINIC	136,178	84,919	1.603622		90.00
90.01	09001	VISITING SPECIALTY CLINIC	816,133	1,014,122	0.804768		90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0	0	0.000000		90.02
91.00	09100	EMERGENCY	6,383,536	26,602,943	0.239956		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,605,476	3,614,620	0.444162		92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	0	0.000000		95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0.000000		101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0.000000		102.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (sum of lines 50 thru 199)	27,185,657	86,885,704			200.00
201.00		Less Observation Beds	1,605,476	0			201.00
202.00		Total (line 200 minus line 201)	25,580,181	86,885,704			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-1306 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part II Date/Time Prepared: 5/30/2023 10:40 am

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	189,658	6,342,158	0.029904	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	24,721	888,596	0.027820	14	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	191,161	16,791,108	0.011385	171,852	1,957	54.00
60.00	06000	LABORATORY	88,409	9,474,543	0.009331	358,450	3,345	60.00
64.00	06400	INTRAVENOUS THERAPY	34,925	2,114,904	0.016514	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	28,815	1,518,293	0.018979	169,382	3,215	65.00
66.00	06600	PHYSICAL THERAPY	102,795	1,769,325	0.058098	67,771	3,937	66.00
67.00	06700	OCCUPATIONAL THERAPY	28,898	683,522	0.042278	51,175	2,164	67.00
68.00	06800	SPEECH PATHOLOGY	15,114	129,328	0.116866	11,654	1,362	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	15,915	90,551	0.175757	242	43	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,913	155,043	0.012339	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	66,161	14,212,859	0.004655	680,419	3,167	73.00
74.00	07400	RENAL DIALYSIS	0	0	0.000000	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0.000000	0	0	75.00
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0	0	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0.000000	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	157,503	1,398,870	0.112593	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	09000	CLINIC	2,521	84,919	0.029687	0	0	90.00
90.01	09001	VISITING SPECIALTY CLINIC	87,761	1,014,122	0.086539	0	0	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0	0	0.000000	0	0	90.02
91.00	09100	EMERGENCY	213,206	26,602,943	0.008014	35,589	285	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	99,068	3,614,620	0.027408	2,380	65	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	1,348,544	86,885,704		1,548,928	19,540	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1306 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part IV | Date/Time Prepared: 5/30/2023 10:40 am

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	541,957	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	VISITING SPECIALTY CLINIC	0	0	0	0	0	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	541,957	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1306 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part IV Date/Time Prepared: 5/30/2023 10:40 am

Title XVIII | Hospital | Cost

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	541,957	0	6,342,158	0.085453	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	888,596	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	16,791,108	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	9,474,543	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	2,114,904	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	1,518,293	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,769,325	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	683,522	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	129,328	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	90,551	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	155,043	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	14,212,859	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0.000000	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0.000000	75.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0.000000	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0.000000	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	1,398,870	0.000000	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0.000000	89.00
90.00	09000	CLINIC	0	0	0	84,919	0.000000	90.00
90.01	09001	VISITING SPECIALTY CLINIC	0	0	0	1,014,122	0.000000	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0	0	0	0	0.000000	90.02
91.00	09100	EMERGENCY	0	0	0	26,602,943	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	3,614,620	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	541,957	0	86,885,704		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1306 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part IV | Date/Time Prepared: 5/30/2023 10:40 am

Title XVIII | Hospital | Cost

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	14	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	171,852	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	358,450	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	169,382	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	67,771	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	51,175	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	11,654	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	242	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	680,419	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	0	0	75.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	0	0	89.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	VISITING SPECIALTY CLINIC	0.000000	0	0	0	0	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0.000000	0	0	0	0	90.02
91.00	09100	EMERGENCY	0.000000	35,589	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	2,380	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		1,548,928	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1306 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part V Date/Time Prepared: 5/30/2023 10:40 am

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.419729	0	801,021	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.674347	0	1,513	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.173096	0	3,698,791	0	0	54.00
60.00	06000	LABORATORY	0.376150	0	1,665,846	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.197161	0	717,830	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.608575	0	294,217	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.558878	0	430,135	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.439461	0	130,699	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1.218035	0	17,923	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2.358428	0	9,825	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.163574	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.238728	0	5,596,577	968	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	0	0	75.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC						88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER						89.00
90.00	09000	CLINIC	1.603622	0	40,476	0	0	90.00
90.01	09001	VISITING SPECIALTY CLINIC	0.804768	0	284,262	0	0	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0.000000	0	0	0	0	90.02
91.00	09100	EMERGENCY	0.239956	0	5,528,781	6,740	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.444162	0	911,435	64,828	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000		0			95.00
200.00		Subtotal (see instructions)		0	20,129,331	72,536	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	20,129,331	72,536	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1306 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part V Date/Time Prepared: 5/30/2023 10:40 am

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	336,212	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,020	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	640,246	0		54.00
60.00	06000	LABORATORY	626,608	0		60.00
64.00	06400	INTRAVENOUS THERAPY	141,528	0		64.00
65.00	06500	RESPIRATORY THERAPY	179,053	0		65.00
66.00	06600	PHYSICAL THERAPY	240,393	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	57,437	0		67.00
68.00	06800	SPEECH PATHOLOGY	21,831	0		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	23,172	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,336,060	231		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0		75.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0		77.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC				88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER				89.00
90.00	09000	CLINIC	64,908	0		90.00
90.01	09001	VISITING SPECIALTY CLINIC	228,765	0		90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0	0		90.02
91.00	09100	EMERGENCY	1,326,664	1,617		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	404,825	28,794		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	5,628,722	30,642		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	5,628,722	30,642		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-1306 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part I Date/Time Prepared: 5/30/2023 10:40 am

Title XIX | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	320,261	5,016	315,245	1,957	161.09	30.00
31.00	INTENSIVE CARE UNIT	0		0	0	0.00	31.00
43.00	NURSERY	14,920		14,920	186	80.22	43.00
200.00	Total (lines 30 through 199)	335,181		330,165	2,143		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)		
		6.00	7.00		
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	39	6,283		30.00
31.00	INTENSIVE CARE UNIT	0	0		31.00
43.00	NURSERY	15	1,203		43.00
200.00	Total (lines 30 through 199)	54	7,486		200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 15-1306 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part II Date/Time Prepared: 5/30/2023 10:40 am

Title XIX | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	189,658	6,342,158	0.029904	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	24,721	888,596	0.027820	20,711	576	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	191,161	16,791,108	0.011385	10,920	124	54.00
60.00	06000	LABORATORY	88,409	9,474,543	0.009331	27,876	260	60.00
64.00	06400	INTRAVENOUS THERAPY	34,925	2,114,904	0.016514	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	28,815	1,518,293	0.018979	16,114	306	65.00
66.00	06600	PHYSICAL THERAPY	102,795	1,769,325	0.058098	5,147	299	66.00
67.00	06700	OCCUPATIONAL THERAPY	28,898	683,522	0.042278	3,280	139	67.00
68.00	06800	SPEECH PATHOLOGY	15,114	129,328	0.116866	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	15,915	90,551	0.175757	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,913	155,043	0.012339	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	66,161	14,212,859	0.004655	55,522	258	73.00
74.00	07400	RENAL DIALYSIS	0	0	0.000000	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0.000000	0	0	75.00
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0	0	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0.000000	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	157,503	1,398,870	0.112593	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	09000	CLINIC	2,521	84,919	0.029687	0	0	90.00
90.01	09001	VISITING SPECIALTY CLINIC	87,761	1,014,122	0.086539	0	0	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0	0	0.000000	0	0	90.02
91.00	09100	EMERGENCY	213,206	26,602,943	0.008014	22,488	180	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	99,068	3,614,620	0.027408	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	1,348,544	86,885,704		162,058	2,142	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1306 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part III Date/Time Prepared: 5/30/2023 10:40 am

Title XIX | Hospital | PPS

		Cost Center Description	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	1,957	0.00	39	30.00
31.00	03100	INTENSIVE CARE UNIT		0	0	0.00	0	31.00
43.00	04300	NURSERY		0	186	0.00	15	43.00
200.00		Total (lines 30 through 199)		0	2,143		54	200.00

		Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
			9.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	31.00
43.00	04300	NURSERY	0	43.00
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1306 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part IV Date/Time Prepared: 5/30/2023 10:40 am

Title XIX | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	541,957	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	VISITING SPECIALTY CLINIC	0	0	0	0	0	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	541,957	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1306 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part IV Date/Time Prepared: 5/30/2023 10:40 am

Title XIX | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	541,957	0	6,342,158	0.085453	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	888,596	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	16,791,108	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	9,474,543	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	2,114,904	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	1,518,293	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,769,325	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	683,522	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	129,328	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	90,551	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	155,043	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	14,212,859	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0.000000	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0.000000	75.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0.000000	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0.000000	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	1,398,870	0.000000	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0.000000	89.00
90.00	09000	CLINIC	0	0	0	84,919	0.000000	90.00
90.01	09001	VISITING SPECIALTY CLINIC	0	0	0	1,014,122	0.000000	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0	0	0	0	0.000000	90.02
91.00	09100	EMERGENCY	0	0	0	26,602,943	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	3,614,620	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	541,957	0	86,885,704		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1306 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part IV | Date/Time Prepared: 5/30/2023 10:40 am

Title XIX | Hospital | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	20,711	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	10,920	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	27,876	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	16,114	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	5,147	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	3,280	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
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	55,522	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	0	0	75.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	0	0	89.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	VISITING SPECIALTY CLINIC	0.000000	0	0	0	0	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0.000000	0	0	0	0	90.02
91.00	09100	EMERGENCY	0.000000	22,488	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		162,058	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1306 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-1 | Date/Time Prepared: 5/30/2023 10:40 am

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,046	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,957	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)	1,342	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	25	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	64	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)	536	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)	25	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)	5,190,105	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)	16,028	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)	81,291	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	5,108,814	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)	5,108,814	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)	2,610.53	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,399,244	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)	1,399,244	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1306 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-1 | Date/Time Prepared: 5/30/2023 10:40 am

Title XVIII | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	514,832	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)	1,914,076	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)	65,263	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	65,263	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)	615	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,610.53	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,605,476	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1306 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-1 | Date/Time Prepared: 5/30/2023 10:40 am

Title XVIII | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	320,261	5,190,105	0.061706	1,605,476	99,068	90.00
91.00	Nursing Program cost	0	5,190,105	0.000000	1,605,476	0	91.00
92.00	Allied health cost	0	5,190,105	0.000000	1,605,476	0	92.00
93.00	All other Medical Education	0	5,190,105	0.000000	1,605,476	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1306 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-1 | Date/Time Prepared: 5/30/2023 10:40 am

Title XIX | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,046	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,957	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)	1,342	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	25	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	64	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)	39	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)	186	15.00
16.00	Nursery days (title V or XIX only)	15	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)	5,190,105	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)	16,028	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)	81,291	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	5,108,814	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)	5,108,814	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)	2,610.53	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	101,811	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)	101,811	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1306 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-1 | Date/Time Prepared: 5/30/2023 10:40 am

Title XIX | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	197,428	186	1,061.44	15	15,922	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	59,118	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)	176,851	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)	7,486	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	2,142	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	9,628	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	167,223	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)	615	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,610.53	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,605,476	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1306 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-1 | Date/Time Prepared: 5/30/2023 10:40 am

Title XIX | Hospital | PPS

	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	320,261	5,190,105	0.061706	1,605,476	99,068	90.00
91.00	Nursing Program cost	0	5,190,105	0.000000	1,605,476	0	91.00
92.00	Allied health cost	0	5,190,105	0.000000	1,605,476	0	92.00
93.00	All other Medical Education	0	5,190,105	0.000000	1,605,476	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1306 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-3 | Date/Time Prepared: 5/30/2023 10:40 am

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		1,217,030		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.419729	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.674347	14	9	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.173096	171,852	29,747	54.00
60.00	06000	LABORATORY	0.376150	358,450	134,831	60.00
64.00	06400	INTRAVENOUS THERAPY	0.197161	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.608575	169,382	103,082	65.00
66.00	06600	PHYSICAL THERAPY	0.558878	67,771	37,876	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.439461	51,175	22,489	67.00
68.00	06800	SPEECH PATHOLOGY	1.218035	11,654	14,195	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2.358428	242	571	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.163574	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.238728	680,419	162,435	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	75.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
90.00	09000	CLINIC	1.603622	0	0	90.00
90.01	09001	VISITING SPECIALTY CLINIC	0.804768	0	0	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0.000000	0	0	90.02
91.00	09100	EMERGENCY	0.239956	35,589	8,540	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.444162	2,380	1,057	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,548,928	514,832	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		1,548,928		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-1306 | Component CCN: 15-Z306 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-3 | Date/Time Prepared: 5/30/2023 10:40 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.419729	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.674347	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.173096	2,162	374	54.00
60.00	06000	LABORATORY	0.376150	8,804	3,312	60.00
64.00	06400	INTRAVENOUS THERAPY	0.197161	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.608575	468	285	65.00
66.00	06600	PHYSICAL THERAPY	0.558878	3,401	1,901	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.439461	1,864	819	67.00
68.00	06800	SPEECH PATHOLOGY	1.218035	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2.358428	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.163574	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.238728	17,056	4,072	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	75.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
90.00	09000	CLINIC	1.603622	0	0	90.00
90.01	09001	VISITING SPECIALTY CLINIC	0.804768	0	0	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0.000000	0	0	90.02
91.00	09100	EMERGENCY	0.239956	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.444162	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		33,755	10,763	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		33,755		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1306 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-3 | Date/Time Prepared: 5/30/2023 10:40 am

Title XIX | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		89,813		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
43.00	04300	NURSERY		22,405		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.419729	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.674347	20,711	13,966	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.173096	10,920	1,890	54.00
60.00	06000	LABORATORY	0.376150	27,876	10,486	60.00
64.00	06400	INTRAVENOUS THERAPY	0.197161	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.608575	16,114	9,807	65.00
66.00	06600	PHYSICAL THERAPY	0.558878	5,147	2,877	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.439461	3,280	1,441	67.00
68.00	06800	SPEECH PATHOLOGY	1.218035	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2.358428	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.163574	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.238728	55,522	13,255	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	75.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	76.97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	1.496321	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	89.00
90.00	09000	CLINIC	1.603622	0	0	90.00
90.01	09001	VISITING SPECIALTY CLINIC	0.804768	0	0	90.01
90.02	09002	PAOLI PRIMARY CARE CLINIC	0.000000	0	0	90.02
91.00	09100	EMERGENCY	0.239956	22,488	5,396	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.444162	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		162,058	59,118	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		162,058		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1306	Period: From 01/01/2022 To 12/31/2022	Worksheet E Part B Date/Time Prepared: 5/30/2023 10:40 am
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	5,659,364	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)	5,659,364	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	5,715,958	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)	77,601	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	3,342,056	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)	2,296,301	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)	2,296,301	30.00
31.00	Primary payer payments	580	31.00
32.00	Subtotal (line 30 minus line 31)	2,295,721	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)	406,134	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	263,987	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	320,146	36.00
37.00	Subtotal (see instructions)	2,559,708	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.75	N95 respirator payment adjustment amount (see instructions)	0	39.75
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	2,559,708	40.00
40.01	Sequestration adjustment (see instructions)	32,252	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
40.03	Sequestration adjustment-PARHM or CHART pass-throughs		40.03
41.00	Interim payments	3,303,478	41.00
41.01	Interim payments-PARHM or CHART		41.01
42.00	Tentative settlement (for contractors use only)	0	42.00
42.01	Tentative settlement-PARHM or CHART (for contractor use only)		42.01
43.00	Balance due provider/program (see instructions)	-776,022	43.00
43.01	Balance due provider/program-PARHM (see instructions)		43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	228,091	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: 15-1306	Period: From 01/01/2022 To 12/31/2022	Worksheet E Part B Date/Time Prepared: 5/30/2023 10:40 am
	Title XVIII	Hospital	Cost

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-1306 | Period: From 01/01/2022 To 12/31/2022 | Worksheet E-1 Part I | Date/Time Prepared: 5/30/2023 10:40 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		1,834,450		3,303,478	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)		1,834,450		3,303,478	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		99,069		776,022	6.02
7.00	Total Medicare program liability (see instructions)		1,735,381		2,527,456	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: 15-1306 | Component CCN: 15-Z306 | Period: From 01/01/2022 To 12/31/2022 | Worksheet E-1 Part I | Date/Time Prepared: 5/30/2023 10:40 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		86,268		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)		86,268		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		10,449		0	6.02
7.00	Total Medicare program liability (see instructions)		75,819		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: 15-1306	Period: From 01/01/2022 To 12/31/2022	Worksheet E-1 Part II Date/Time Prepared: 5/30/2023 10:40 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: 15-1306 | Component CCN: 15-Z306 | Period: From 01/01/2022 To 12/31/2022 | Worksheet E-2 | Date/Time Prepared: 5/30/2023 10:40 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)	65,916	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)	10,871	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	25	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)	76,787	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	76,787	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)	76,787	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	0	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (see instructions)	76,787	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)	76,787	0	19.00
19.01	Sequestration adjustment (see instructions)	968	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	86,268	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)	-10,449	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	2,937	0	23.00
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
	Cost Reimbursement			
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))			201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))			202.00
203.00	Total (sum of lines 201 and 202)			203.00
204.00	Medicare swing-bed SNF discharges (see instructions)			204.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
205.00	Medicare swing-bed SNF target amount			205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)			206.00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)			208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
	Comparision of PPS versus Cost Reimbursement			
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)			215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1306	Period: From 01/01/2022 To 12/31/2022	Worksheet E-3 Part V Date/Time Prepared: 5/30/2023 10:40 am
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	1,914,076	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)	1,914,076	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	1,933,217	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)	1,933,217	19.00
20.00	Deductibles (exclude professional component)	187,916	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	1,745,301	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	1,745,301	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	18,808	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	12,225	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	9,264	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	1,757,526	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)	1,757,526	30.00
30.01	Sequestration adjustment (see instructions)	22,145	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
30.03	Sequestration adjustment-PARHM or CHART		30.03
31.00	Interim payments	1,834,450	31.00
31.01	Interim payments-PARHM or CHART		31.01
32.00	Tentative settlement (for contractor use only)	0	32.00
32.01	Tentative settlement-PARHM or CHART (for contractor use only)		32.01
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)	-99,069	33.00
33.01	Balance due provider/program-PARHM or CHART (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01)		33.01
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	73,907	34.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 15-1306 | Period: From 01/01/2022 To 12/31/2022 | Worksheet G | Date/Time Prepared: 5/30/2023 10:40 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	20,830,896	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	8,625	0	0	0	3.00
4.00	Accounts receivable	3,545,245	0	0	0	4.00
5.00	Other receivable	306,040	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	599,356	0	0	0	7.00
8.00	Prepaid expenses	92,844	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)	25,383,006	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	183,505	0	0	0	12.00
13.00	Land improvements	625,604	0	0	0	13.00
14.00	Accumulated depreciation	-437,671	0	0	0	14.00
15.00	Buildings	11,267,245	0	0	0	15.00
16.00	Accumulated depreciation	-4,372,418	0	0	0	16.00
17.00	Leasehold improvements	791,602	0	0	0	17.00
18.00	Accumulated depreciation	-791,602	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	80,607	0	0	0	21.00
22.00	Accumulated depreciation	-53,945	0	0	0	22.00
23.00	Major movable equipment	13,000,418	0	0	0	23.00
24.00	Accumulated depreciation	-8,913,388	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)	11,379,957	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	1,081,817	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	9,408,962	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	10,490,779	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	47,253,742	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	2,285,785	0	0	0	37.00
38.00	Salaries, wages, and fees payable	797,092	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	4,069,239	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	7,152,116	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	41,833	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	41,833	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	7,193,949	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	40,059,793				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)	40,059,793	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	47,253,742	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-1306 | Period: From 01/01/2022 To 12/31/2022 | Worksheet G-1 | Date/Time Prepared: 5/30/2023 10:40 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		38,645,941		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		1,398,632				2.00
3.00	Total (sum of line 1 and line 2)		40,044,573		0		3.00
4.00	DONATED PPE	15,220		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		15,220		0		10.00
11.00	Subtotal (line 3 plus line 10)		40,059,793		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		40,059,793		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	DONATED PPE		0			4.00
5.00			0			5.00
6.00			0			6.00
7.00			0			7.00
8.00			0			8.00
9.00			0			9.00
10.00	Total additions (sum of line 4-9)	0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0		11.00
12.00	Deductions (debit adjustments) (specify)		0			12.00
13.00			0			13.00
14.00			0			14.00
15.00			0			15.00
16.00			0			16.00
17.00			0			17.00
18.00	Total deductions (sum of lines 12-17)	0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0		19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 15-1306 | Period: From 01/01/2022 To 12/31/2022 | Worksheet G-2 Parts I & II | Date/Time Prepared: 5/30/2023 10:40 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	3,514,667		3,514,667	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	85,440		85,440	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)	3,600,107		3,600,107	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	0		0	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)	3,600,107		3,600,107	17.00
18.00	Ancillary services	5,188,612	48,981,618	54,170,230	18.00
19.00	Outpatient services	225,938	31,090,666	31,316,604	19.00
20.00	RURAL HEALTH CLINIC	0	1,398,870	1,398,870	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	0	0	0	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER NRCC	0	11,510	11,510	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	9,014,657	81,482,664	90,497,321	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		32,730,703		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)		32,730,703		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 15-1306	Period: From 01/01/2022 To 12/31/2022	Worksheet G-3 Date/Time Prepared: 5/30/2023 10:40 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	90,497,321	1.00
2.00	Less contractual allowances and discounts on patients' accounts	56,100,163	2.00
3.00	Net patient revenues (line 1 minus line 2)	34,397,158	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	32,730,703	4.00
5.00	Net income from service to patients (line 3 minus line 4)	1,666,455	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	-267,823	24.00
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	-267,823	25.00
26.00	Total (line 5 plus line 25)	1,398,632	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)	1,398,632	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1306 | Component CCN: 15-8557 | Period: From 01/01/2022 To 12/31/2022 | Worksheet M-1 | Date/Time Prepared: 5/30/2023 10:40 am

RHC I | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	-8,036	1,596	-6,440	342	-6,098	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	424,056	75,271	499,327	-41,085	458,242	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	425,869	0	425,869	0	425,869	9.00
10.00	Subtotal (sum of lines 1 through 9)	841,889	76,867	918,756	-40,743	878,013	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	23,337	23,337	-6,697	16,640	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	180	180	0	180	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	23,517	23,517	-6,697	16,820	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	841,889	100,384	942,273	-47,440	894,833	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	218,138	218,138	-208,682	9,456	29.00
30.00	Administrative Costs	0	175,538	175,538	-128,499	47,039	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	393,676	393,676	-337,181	56,495	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	841,889	494,060	1,335,949	-384,621	951,328	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1306 | Component CCN: 15-8557 | Period: From 01/01/2022 To 12/31/2022 | Worksheet M-1 | Date/Time Prepared: 5/30/2023 10:40 am

RHC I | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	6,098	0		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	458,242		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	0		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	425,869		9.00
10.00	Subtotal (sum of lines 1 through 9)	6,098	884,111		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		14.00
15.00	Medical Supplies	0	16,640		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	180		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	16,820		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	6,098	900,931		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	0		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	36,922	46,378		29.00
30.00	Administrative Costs	-1,052	45,987		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	35,870	92,365		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	41,968	993,296		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-1306 | Component CCN: 15-8557 | Period: From 01/01/2022 To 12/31/2022 | Worksheet M-2 | Date/Time Prepared: 5/30/2023 10:40 am

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	RHC I Minimum Visits (col. 1 x col. 3)	Cost Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.00	0	4,200	0		1.00
2.00	Physician Assistant	0.00	0	0	0		2.00
3.00	Nurse Practitioner	2.31	9,036	2,100	4,851		3.00
4.00	Subtotal (sum of lines 1 through 3)	2.31	9,036		4,851	9,036	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	2.31	9,036			9,036	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					900,931	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					900,931	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					92,365	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					1,099,863	15.00
16.00	Total overhead (sum of lines 14 and 15)					1,192,228	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					1,192,228	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					1,192,228	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					2,093,159	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 15-1306 Component CCN: 15-8557	Period: From 01/01/2022 To 12/31/2022	Worksheet M-3 Date/Time Prepared: 5/30/2023 10:40 am
	Title XVIII	RHC I	Cost

		1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES		
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)	2,093,159	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)	3,192	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)	2,089,967	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)	9,036	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)	0	5.00
6.00	Total adjusted visits (line 4 plus line 5)	9,036	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)	231.29	7.00

		Calculation of Limit (1)		
		Rate Period N/A	Rate Period 1 (01/01/2022 through 12/31/2022)	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	0.00	412.73	8.00
9.00	Rate for Program covered visits (see instructions)	0.00	231.29	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	589	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	136,230	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)			15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	136,230	16.00
16.01	Total program charges (see instructions)(from contractor's records)		97,844	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		5,193	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		7,230	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		91,933	16.04
16.05	Total program cost (see instructions)	0	99,163	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		14,084	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		15,713	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		99,163	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		1,064	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		100,227	22.00
23.00	Allowable bad debts (see instructions)		0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	25.50
25.99	Demonstration payment adjustment amount before sequestration		0	25.99
26.00	Net reimbursable amount (see instructions)		100,227	26.00
26.01	Sequestration adjustment (see instructions)		1,263	26.01
26.02	Demonstration payment adjustment amount after sequestration		15,637	26.02
27.00	Interim payments		78,320	27.00
28.00	Tentative settlement (for contractor use only)		0	28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)		5,007	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		4,255	30.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 15-1306 | Component CCN: 15-8557 | Period: From 01/01/2022 To 12/31/2022 | Worksheet M-4 | Date/Time Prepared: 5/30/2023 10:40 am

Title XVIII | RHC I | Cost

		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	884,111	884,111	884,111	884,111	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000000	0.000573	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	0	507	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	0	867	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	0	1,374	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	900,931	900,931	900,931	900,931	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	1,192,228	1,192,228	1,192,228	1,192,228	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.000000	0.001525	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	0	1,818	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	0	3,192	0	0	10.00
11.00	Total number of injections/infusions (from your records)	18	54	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	0.00	59.11	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	0	18	0	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	0	1,064	0	0	14.00

		COST OF INJECTIONS / INFUSIONS AND ADMINISTRATION	
		1.00	2.00	
15.00	Total cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. M-3, line 2)		3,192	15.00
16.00	Total Program cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount to Wkst. M-3, line 21)		1,064	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 15-1306 Component CCN: 15-8557	Period: From 01/01/2022 To 12/31/2022	Worksheet M-5 Date/Time Prepared: 5/30/2023 10:40 am
		RHC I	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		78,320	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	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			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		78,320	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			0	5.01
5.02			0	5.02
5.03			0	5.03
	Provider to Program			
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		5,007	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		83,327	7.00

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