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: 15-0001	Period: From 01/01/2022 To 12/31/2022	Worksheet S Parts I-III Date/Time Prepared: 5/24/2023 9:39 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 5/24/2023 Time: 9:39 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 JOHNSON MEMORIAL HOSPITAL (15-0001) 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	Steve Berkhouse		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	Steve Berkhouse			2
3	Signatory Title	CFO			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	121,761	50,766	0	-135,984	1.00
2.00	SUBPROVIDER - IPF	0	0	0		0	2.00
3.00	SUBPROVIDER - IRF	0	0	0		0	3.00
5.00	SWING BED - SNF	0	0	0		0	5.00
6.00	SWING BED - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
200.00	TOTAL	0	121,761	50,766	0	-135,984	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: 15-0001 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-2 Part I Date/Time Prepared: 5/24/2023 9:39 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1125 WEST JEFFERSON STREET	PO Box:			1.00
2.00	City: FRANKLIN	State: IN	Zip Code: 46131-	County: JOHNSON	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	JOHNSON MEMORIAL HOSPITAL	150001	26900	1	07/01/1966	N	P	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									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	JOHNSON MEMORIAL HOME HEALTH	157510	26900		07/01/1997	N	P	N	12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2022	12/31/2022	20.00
21.00	Type of Control (see instructions)	9		21.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0001 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-2 Part I | Date/Time Prepared: 5/24/2023 9:39 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.	105	1,031	0	0	497	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.	1		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	1		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0001	Period: From 01/01/2022 To 12/31/2022	Worksheet S-2 Part I Date/Time Prepared: 5/24/2023 9:39 am

		V	XVIII	XIX	
		1.00	2.00	3.00	
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0001	Period: From 01/01/2022 To 12/31/2022	Worksheet S-2 Part I Date/Time Prepared: 5/24/2023 9:39 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: 15-0001 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-2 Part I Date/Time Prepared: 5/24/2023 9:39 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)	N	N	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)	N	N	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.	Y	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0001 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-2 Part I Date/Time Prepared: 5/24/2023 9:39 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.	Y	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.	Y	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.	Y	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.	Y	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.	Y	Y	98.06
	Rural Providers			
105.00	Does this hospital qualify as a CAH?	N		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0001 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-2 Part I | Date/Time Prepared: 5/24/2023 9:39 am

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	556,194	0	0	118.01

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

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name:	Contractor's Name:	Contractor's Number:	141.00
142.00	Street:	PO Box:		142.00
143.00	City:	State:	Zip Code:	143.00

		1.00	
144.00	Are provider based physicians' costs included in Worksheet A?	Y	144.00

		1.00	2.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.			145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146.00

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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)			168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)		9.99	169.00

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170.00
		1.00	2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N	0	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-0001 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-2 Part II | Date/Time Prepared: 5/24/2023 9:39 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)	N			3.00

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

		Y/N	Legal Oper.	
		1.00	2.00	
	Approved Educational Activities			
6.00	Column 1: Are costs claimed for a nursing program? Column 2: If yes, is the provider the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	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)	Y	03/30/2023	Y	03/30/2023	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-0001 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-2 Part II Date/Time Prepared: 5/24/2023 9:39 am

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

		1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)		
	Capital Related Cost		
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions		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.		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		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.		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		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		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.		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.		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.		35.00

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

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	TINA	SEVERS	41.00
42.00	Enter the employer/company name of the cost report preparer.	BLUE & CO		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-713-7946	TSEVERS@BLUEANDCO.COM	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.	MANAGER		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: 15-0001 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-3 Part I | Date/Time Prepared: 5/24/2023 9:39 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	44	16,060	0.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		44	16,060	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	14	5,110	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)		58	21,170	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	41.00	0	0		0	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		58				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care	30.00	0	0		0	34.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-0001 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-3 Part I | Date/Time Prepared: 5/24/2023 9:39 am

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,711	73	5,155			1.00
2.00	HMO and other (see instructions)	1,184	1,358				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,711	73	5,155			7.00
8.00	INTENSIVE CARE UNIT	510	4	1,544			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		17	508			13.00
14.00	Total (see instructions)	2,221	94	7,207	0.00	613.73	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	0	0	0	0.00	0.00	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	883	0	2,900	0.00	7.01	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			17			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	620.74	27.00
28.00	Observation Bed Days		106	2,692			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	181	309			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: 15-0001 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-3 Part I | Date/Time Prepared: 5/24/2023 9:39 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	519	28	1,851	1.00
2.00	HMO and other (see instructions)			238	412		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	519	28	1,851	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	0.00	0	0	0	0	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care						34.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0001 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-3 Part II Date/Time Prepared: 5/24/2023 9:39 am

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	48,708,818	-72,351	48,636,467	1,291,148.25	37.67	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician and Non Physician-Part B		1,794,251	0	1,794,251	18,631.00	96.30	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		14,917,497	0	14,917,497	315,594.31	47.27	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		5,986,765	0	5,986,765	46,589.00	128.50	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		17,313	0	17,313	96.00	180.34	13.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00	14.00
14.01	Home office salaries		0	0	0	0.00	0.00	14.01
14.02	Related organization salaries		0	0	0	0.00	0.00	14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00	16.01
16.02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.02
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		7,465,661	0	7,465,661			17.00
18.00	Wage-related costs (other) (see instructions)							18.00
19.00	Excluded areas		2,997,968	0	2,997,968			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		210,817	0	210,817			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
25.50	Home office wage-related (core)		0	0	0			25.50
25.51	Related organization wage-related (core)		0	0	0			25.51
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0			25.52

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0001 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-3 Part II Date/Time Prepared: 5/24/2023 9:39 am

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.53	Home office: Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	3,600,471	-5,067	3,595,404	149,308.31	24.08	26.00
27.00	Administrative & General	5.00	1,496,137	-8,815	1,487,322	75,665.12	19.66	27.00
28.00	Administrative & General under contract (see inst.)		3,377,095	0	3,377,095	34,790.00	97.07	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	954,575	0	954,575	35,679.43	26.75	30.00
31.00	Laundry & Linen Service	8.00	115,332	0	115,332	6,342.53	18.18	31.00
32.00	Housekeeping	9.00	737,716	0	737,716	37,099.93	19.88	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	619,888	-361,955	257,933	8,334.00	30.95	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	353,584	353,584	22,552.00	15.68	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,135,702	-15,000	1,120,702	20,088.10	55.79	38.00
39.00	Central Services and Supply	14.00	87,276	0	87,276	4,449.20	19.62	39.00
40.00	Pharmacy	15.00	993,803	0	993,803	22,849.35	43.49	40.00
41.00	Medical Records & Medical Records Library	16.00	652,706	0	652,706	29,047.80	22.47	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0001 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-3 Part III Date/Time Prepared: 5/24/2023 9:39 am

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		50,291,662	-72,351	50,219,311	1,307,307.25	38.41	1.00
2.00	Excluded area salaries (see instructions)		14,917,497	0	14,917,497	315,594.31	47.27	2.00
3.00	Subtotal salaries (line 1 minus line 2)		35,374,165	-72,351	35,301,814	991,712.94	35.60	3.00
4.00	Subtotal other wages & related costs (see inst.)		6,004,078	0	6,004,078	46,685.00	128.61	4.00
5.00	Subtotal wage-related costs (see inst.)		7,465,661	0	7,465,661	0.00	21.15	5.00
6.00	Total (sum of lines 3 thru 5)		48,843,904	-72,351	48,771,553	1,038,397.94	46.97	6.00
7.00	Total overhead cost (see instructions)		13,770,701	-37,253	13,733,448	446,205.77	30.78	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 15-0001 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-3 Part IV Date/Time Prepared: 5/24/2023 9:39 am

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	738,846	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	6,199,890	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	60,506	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	98,829	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	302,657	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Noncumulative portion)	0	16.00
	TAXES		
17.00	FICA-Employers Portion Only	3,261,484	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	3,157	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	9,078	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	10,674,447	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 15-0001 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-3 Part V Date/Time Prepared: 5/24/2023 9:39 am

	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	5,986,765	10,674,447	1.00
2.00	Hospital	5,986,765	10,674,447	2.00
3.00	SUBPROVIDER - IPF			3.00
4.00	SUBPROVIDER - IRF	0	0	4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	SKILLED NURSING FACILITY			8.00
9.00	NURSING FACILITY			9.00
10.00	OTHER LONG TERM CARE I			10.00
11.00	Hospital-Based HHA	0	0	11.00
12.00	AMBULATORY SURGICAL CENTER (D.P.) I			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	RENAL DIALYSIS I			17.00
18.00	Other	0	0	18.00

HOME HEALTH AGENCY STATISTICAL DATA | Provider CCN: 15-0001 | Component CCN: 15-7510 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-4 | Date/Time Prepared: 5/24/2023 9:39 am

Home Health Agency I | PPS

						1.00	
0.00	County				JOHNSON		0.00
		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
	HOME HEALTH AGENCY STATISTICAL DATA						
1.00	Home Health Aide Hours	0	2,065	0	0	2,065	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	122.00	0.00	0.00	0.00	2.00
				Number of Employees (Full Time Equivalent)			
		Enter the number of hours in your normal work week		Staff	Contract	Total	
		0		1.00	2.00	3.00	
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES						
3.00	Administrator and Assistant Administrator(s)		40.00	0.60	0.00	0.60	3.00
4.00	Director(s) and Assistant Director(s)			0.00	0.00	0.00	4.00
5.00	Other Administrative Personnel			0.65	0.00	0.65	5.00
6.00	Direct Nursing Service			2.56	0.00	2.56	6.00
7.00	Nursing Supervisor			0.00	0.00	0.00	7.00
8.00	Physical Therapy Service			1.04	0.00	1.04	8.00
9.00	Physical Therapy Supervisor			0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service			0.64	0.00	0.64	10.00
11.00	Occupational Therapy Supervisor			0.00	0.00	0.00	11.00
12.00	Speech Pathology Service			0.00	0.00	0.00	12.00
13.00	Speech Pathology Supervisor			0.00	0.00	0.00	13.00
14.00	Medical Social Service			0.00	0.00	0.00	14.00
15.00	Medical Social Service Supervisor			0.00	0.00	0.00	15.00
16.00	Home Health Aide			0.64	0.00	0.64	16.00
17.00	Home Health Aide Supervisor			0.00	0.00	0.00	17.00
18.00	DIETICIAN			0.02	0.00	0.02	18.00
						CBSA Data	
						1.00	
	HOME HEALTH AGENCY CBSA CODES						
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.					1	19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).					18020	20.00
		Full Episodes					
		Without Outliers	With Outliers	LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		1.00	2.00	3.00	4.00	5.00	
	PPS ACTIVITY DATA						
21.00	Skilled Nursing Visits	286	0	5	0	291	21.00
22.00	Skilled Nursing Visit Charges	134,680	0	2,500	0	137,180	22.00
23.00	Physical Therapy Visits	339	0	10	0	349	23.00
24.00	Physical Therapy Visit Charges	179,940	0	4,700	0	184,640	24.00
25.00	Occupational Therapy Visits	232	0	0	0	232	25.00
26.00	Occupational Therapy Visit Charges	125,120	0	0	0	125,120	26.00
27.00	Speech Pathology Visits	0	0	0	0	0	27.00
28.00	Speech Pathology Visit Charges	0	0	0	0	0	28.00
29.00	Medical Social Service Visits	0	0	0	0	0	29.00
30.00	Medical Social Service Visit Charges	0	0	0	0	0	30.00
31.00	Home Health Aide Visits	11	0	0	0	11	31.00
32.00	Home Health Aide Visit Charges	3,355	0	0	0	3,355	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	868	0	15	0	883	33.00
34.00	Other Charges	99	0	0	0	99	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	443,194	0	7,200	0	450,394	35.00
36.00	Total Number of Episodes (standard/non outlier)	115		7	0	122	36.00
37.00	Total Number of Outlier Episodes		0		0	0	37.00
38.00	Total Non-Routine Medical Supply Charges	0	0	0	0	0	38.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-0001 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-10 | Date/Time Prepared: 5/24/2023 9:39 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)	0.220233	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	3,021,261	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	50,803,300	6.00
7.00	Medicaid cost (line 1 times line 6)	11,188,563	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)	8,167,302	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	8,167,302	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)	2,671,914	940,798	3,612,712	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	588,444	940,798	1,529,242	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)	588,444	940,798	1,529,242	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)	12,470,234	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	92,542	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	142,373	27.01
28.00	Non-Medicare bad debt expense (see instructions)	12,327,861	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	2,764,833	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	4,294,075	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	12,461,377	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0001 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A | Date/Time Prepared: 5/24/2023 9:39 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	NEW CAP REL COSTS-BLDG & FIXT		3,065,371	3,065,371	0	3,065,371	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		4,173,319	4,173,319	0	4,173,319	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	410,288	10,631,807	11,042,095	18,625	11,060,720	4.00
4.01	00401	COMMUNICATIONS	109,593	278,211	387,804	0	387,804	4.01
4.02	00402	DATA PROCESSING	773,334	3,008,665	3,781,999	-416	3,781,583	4.02
4.03	00403	MATERIALS MANAGEMENT	414,053	44,488	458,541	-160	458,381	4.03
4.04	00404	ADMITTING	984,769	23,506	1,008,275	-3,846	1,004,429	4.04
4.05	00405	PATIENT ACCOUNTING	908,434	709,810	1,618,244	-214	1,618,030	4.05
5.00	00500	ADMINISTRATIVE & GENERAL	1,496,137	7,008,462	8,504,599	-19,190	8,485,409	5.00
7.00	00700	OPERATION OF PLANT	954,575	3,679,286	4,633,861	-403	4,633,458	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	115,332	90,085	205,417	-3,172	202,245	8.00
9.00	00900	HOUSEKEEPING	737,716	101,307	839,023	-9,367	829,656	9.00
10.00	01000	DIETARY	619,888	434,766	1,054,654	-602,323	452,331	10.00
11.00	01100	CAFETERIA	0	0	0	601,575	601,575	11.00
13.00	01300	NURSING ADMINISTRATION	1,135,702	115,359	1,251,061	-271	1,250,790	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	87,276	62,807	150,083	-60,271	89,812	14.00
15.00	01500	PHARMACY	993,803	7,941,015	8,934,818	-7,241,690	1,693,128	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	652,706	241,053	893,759	-61	893,698	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,458,382	2,197,051	8,655,433	-533,225	8,122,208	30.00
31.00	03100	INTENSIVE CARE UNIT	1,112,759	1,562,442	2,675,201	-67,764	2,607,437	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	0	0	0	269,193	269,193	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,275,794	957,260	3,233,054	-340,488	2,892,566	50.00
53.00	05300	ANESTHESIOLOGY	986,323	1,244,338	2,230,661	27,086	2,257,747	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,316,400	1,039,366	3,355,766	-107,299	3,248,467	54.00
60.00	06000	LABORATORY	1,974,182	4,164,011	6,138,193	-212,395	5,925,798	60.00
65.00	06500	RESPIRATORY THERAPY	1,620,068	497,884	2,117,952	-55,194	2,062,758	65.00
66.00	06600	PHYSICAL THERAPY	901,964	61,932	963,896	-15,671	948,225	66.00
67.00	06700	OCCUPATIONAL THERAPY	301,511	160	301,671	0	301,671	67.00
68.00	06800	SPEECH PATHOLOGY	152,602	1,342	153,944	0	153,944	68.00
69.00	06900	ELECTROCARDIOLOGY	407,388	203,386	610,774	-10,371	600,403	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	16,381	100,318	116,699	-318	116,381	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4,163,289	4,163,289	-1,971,348	2,191,941	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	3,545,012	3,545,012	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	7,929,577	7,929,577	73.00
76.00	03020	ONCOLOGY	551,559	185,152	736,711	-109,051	627,660	76.00
76.97	07697	CARDIAC REHABILITATION	169,014	135,484	304,498	-8,164	296,334	76.97
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	838,866	1,578,884	2,417,750	-171,133	2,246,617	90.00
91.00	09100	EMERGENCY	3,314,522	2,714,472	6,028,994	-196,999	5,831,995	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	591,206	138,590	729,796	-5,025	724,771	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)	34,382,527	62,554,678	96,937,205	645,239	97,582,444	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	184,431	33,376	217,807	-7,315	210,492	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	14,061,813	3,561,070	17,622,883	-633,505	16,989,378	192.00
192.01	19201	SOUTH CLINIC	0	0	0	0	0	192.01
192.02	19202	WEST CLINIC	0	0	0	0	0	192.02
192.03	19203	DIABETES CENTER	80,047	4,983	85,030	-4,410	80,620	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	ADULT/CHILD CARE	0	0	0	0	0	193.01
193.02	19302	PHYSICIAN OFFICE BUILDING	0	875,616	875,616	-9	875,607	193.02
193.03	19303	OPTIFAST/FOUNDATION	0	0	0	0	0	193.03
194.00	07950	PARTNERSHIP HFC	0	483	483	0	483	194.00
194.01	07951	TRAFALGAR CLINIC	0	0	0	0	0	194.01
194.02	07952	EDINBURGH	0	0	0	0	0	194.02
194.03	07953	JAIL	0	0	0	0	0	194.03
194.04	07954	ATHLETIC TRAINERS	0	0	0	0	0	194.04
200.00		TOTAL (SUM OF LINES 118 through 199)	48,708,818	67,030,206	115,739,024	0	115,739,024	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0001 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A | Date/Time Prepared: 5/24/2023 9:39 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	-88,563	2,976,808		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	4,173,319		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-7,716	11,053,004		4.00
4.01	00401	COMMUNICATIONS	-37,205	350,599		4.01
4.02	00402	DATA PROCESSING	0	3,781,583		4.02
4.03	00403	MATERIALS MANAGEMENT	0	458,381		4.03
4.04	00404	ADMITTING	0	1,004,429		4.04
4.05	00405	PATIENT ACCOUNTING	0	1,618,030		4.05
5.00	00500	ADMINISTRATIVE & GENERAL	-4,738,776	3,746,633		5.00
7.00	00700	OPERATION OF PLANT	-56,528	4,576,930		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	202,245		8.00
9.00	00900	HOUSEKEEPING	0	829,656		9.00
10.00	01000	DIETARY	184	452,515		10.00
11.00	01100	CAFETERIA	-158,831	442,744		11.00
13.00	01300	NURSING ADMINISTRATION	6,134	1,256,924		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	89,812		14.00
15.00	01500	PHARMACY	0	1,693,128		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-48,750	844,948		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-2,231,821	5,890,387		30.00
31.00	03100	INTENSIVE CARE UNIT	0	2,607,437		31.00
41.00	04100	SUBPROVIDER - IRF	0	0		41.00
43.00	04300	NURSERY	0	269,193		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	2,892,566		50.00
53.00	05300	ANESTHESIOLOGY	-1,125,977	1,131,770		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,248,467		54.00
60.00	06000	LABORATORY	-35,254	5,890,544		60.00
65.00	06500	RESPIRATORY THERAPY	0	2,062,758		65.00
66.00	06600	PHYSICAL THERAPY	-123	948,102		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	301,671		67.00
68.00	06800	SPEECH PATHOLOGY	0	153,944		68.00
69.00	06900	ELECTROCARDIOLOGY	0	600,403		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	-100,000	16,381		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	-1,292	2,190,649		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	3,545,012		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	7,929,577		73.00
76.00	03020	ONCOLOGY	-9,368	618,292		76.00
76.97	07697	CARDIAC REHABILITATION	-95,150	201,184		76.97
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0		77.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	-92,400	2,154,217		90.00
91.00	09100	EMERGENCY	-1,902,805	3,929,190		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	724,771		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)	-10,724,241	86,858,203		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	210,492		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	16,989,378		192.00
192.01	19201	SOUTH CLINIC	0	0		192.01
192.02	19202	WEST CLINIC	0	0		192.02
192.03	19203	DIABETES CENTER	0	80,620		192.03
193.00	19300	NONPAID WORKERS	0	0		193.00
193.01	19301	ADULT/CHILD CARE	0	0		193.01
193.02	19302	PHYSICIAN OFFICE BUILDING	0	875,607		193.02
193.03	19303	OPTIFAST/FOUNDATION	0	0		193.03
194.00	07950	PARTNERSHIP HFC	0	483		194.00
194.01	07951	TRAFALGAR CLINIC	0	0		194.01
194.02	07952	EDINBURGH	0	0		194.02
194.03	07953	JAIL	0	0		194.03
194.04	07954	ATHLETIC TRAINERS	0	0		194.04
200.00		TOTAL (SUM OF LINES 118 through 199)	-10,724,241	105,014,783		200.00

RECLASSIFICATIONS | Provider CCN: 15-0001 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-6 | Date/Time Prepared: 5/24/2023 9:39 am

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - NURSERY RECLASS					
1.00	NURSERY	43.00	232,234	36,959		1.00
	TOTALS		232,234	36,959		
	B - IMPLANTABLE DEVICE RECLASS					
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00		3,545,012		1.00
	TOTALS		0	3,545,012		
	C - CAFETERIA RECLASS					
1.00	CAFETERIA	11.00	353,584	247,991		1.00
	TOTALS		353,584	247,991		
	D - SHORT TERM DISABILITY RECLASS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	5,458		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	8,424		2.00
3.00	DIETARY	10.00	0	8,371		3.00
4.00	NURSING ADMINISTRATION	13.00	0	15,000		4.00
5.00	OPERATING ROOM	50.00	0	3,269		5.00
6.00	ANESTHESIOLOGY	53.00	0	6,000		6.00
7.00	CLINIC	90.00	0	25,829		7.00
	TOTALS		0	72,351		
	E - EMPLOYEE WELLNESS RECLASS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	391	18,273		1.00
	TOTALS		391	18,273		
	F - PART A RECLASS					
1.00	ADULTS & PEDIATRICS	30.00	0	4,200		1.00
2.00	ANESTHESIOLOGY	53.00	0	27,527		2.00
	TOTALS		0	31,727		
	G - MEDICAL SUPPLIES RECLASS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	1,573,664		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
20.00		0.00	0	0		20.00
21.00		0.00	0	0		21.00
22.00		0.00	0	0		22.00
23.00		0.00	0	0		23.00
24.00		0.00	0	0		24.00
25.00		0.00	0	0		25.00
26.00		0.00	0	0		26.00
27.00		0.00	0	0		27.00
28.00		0.00	0	0		28.00
29.00		0.00	0	0		29.00
30.00		0.00	0	0		30.00
31.00		0.00	0	0		31.00
32.00		0.00	0	0		32.00
33.00		0.00	0	0		33.00
	TOTALS		0	1,573,664		
	H - DRUGS CHARGEABLE RECLASS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	7,929,577		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

RECLASSIFICATIONS | Provider CCN: 15-0001 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-6 | Date/Time Prepared: 5/24/2023 9:39 am

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
	TOTALS		0	7,929,577	
500.00	Grand Total: Increases		586,209	13,455,554	500.00

RECLASSIFICATIONS | Provider CCN: 15-0001 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-6 | Date/Time Prepared: 5/24/2023 9:39 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - NURSERY RECLASS						
1.00	ADULTS & PEDIATRICS	30.00	232,234	36,959	0		1.00
	TOTALS		232,234	36,959			
	B - IMPLANTABLE DEVICE RECLASS						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00		3,545,012	0		1.00
	TOTALS		0	3,545,012			
	C - CAFETERIA RECLASS						
1.00	DIETARY	10.00	353,584	247,991	0		1.00
	TOTALS		353,584	247,991			
	D - SHORT TERM DISABILITY RECLASS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	5,458	0	0		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	8,424	0	0		2.00
3.00	DIETARY	10.00	8,371	0	0		3.00
4.00	NURSING ADMINISTRATION	13.00	15,000	0	0		4.00
5.00	OPERATING ROOM	50.00	3,269	0	0		5.00
6.00	ANESTHESIOLOGY	53.00	6,000	0	0		6.00
7.00	CLINIC	90.00	25,829	0	0		7.00
	TOTALS		72,351	0			
	E - EMPLOYEE WELLNESS RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	391	18,273	0		1.00
	TOTALS		391	18,273			
	F - PART A RECLASS						
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	27,527	0		1.00
2.00	DIABETES CENTER	192.03	0	4,200	0		2.00
	TOTALS		0	31,727			
	G - MEDICAL SUPPLIES RECLASS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	39	0		1.00
2.00	DATA PROCESSING	4.02	0	416	0		2.00
3.00	MATERIALS MANAGEMENT	4.03	0	160	0		3.00
4.00	ADMITTING	4.04	0	3,846	0		4.00
5.00	PATIENT ACCOUNTING	4.05	0	214	0		5.00
6.00	ADMINISTRATIVE & GENERAL	5.00	0	387	0		6.00
7.00	OPERATION OF PLANT	7.00	0	399	0		7.00
8.00	LAUNDRY & LINEN SERVICE	8.00	0	3,172	0		8.00
9.00	HOUSEKEEPING	9.00	0	9,367	0		9.00
10.00	DIETARY	10.00	0	748	0		10.00
11.00	NURSING ADMINISTRATION	13.00	0	270	0		11.00
12.00	CENTRAL SERVICES & SUPPLY	14.00	0	60,271	0		12.00
13.00	PHARMACY	15.00	0	4,805	0		13.00
14.00	MEDICAL RECORDS & LIBRARY	16.00	0	61	0		14.00
15.00	ADULTS & PEDIATRICS	30.00	0	265,183	0		15.00
16.00	INTENSIVE CARE UNIT	31.00	0	67,146	0		16.00
17.00	OPERATING ROOM	50.00	0	340,357	0		17.00
18.00	ANESTHESIOLOGY	53.00	0	441	0		18.00
19.00	RADIOLOGY-DIAGNOSTIC	54.00	0	90,808	0		19.00
20.00	LABORATORY	60.00	0	212,395	0		20.00
21.00	RESPIRATORY THERAPY	65.00	0	49,142	0		21.00
22.00	PHYSICAL THERAPY	66.00	0	15,666	0		22.00
23.00	ELECTROCARDIOLOGY	69.00	0	10,371	0		23.00
24.00	ELECTROENCEPHALOGRAPHY	70.00	0	318	0		24.00
25.00	ONCOLOGY	76.00	0	12,388	0		25.00
26.00	CARDIAC REHABILITATION	76.97	0	8,164	0		26.00
27.00	CLINIC	90.00	0	96,494	0		27.00
28.00	EMERGENCY	91.00	0	196,919	0		28.00
29.00	HOME HEALTH AGENCY	101.00	0	5,025	0		29.00
30.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00	0	7,315	0		30.00
31.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	111,158	0		31.00
32.00	DIABETES CENTER	192.03	0	210	0		32.00
33.00	PHYSICIAN OFFICE BUILDING	193.02	0	9	0		33.00
	TOTALS		0	1,573,664			
	H - DRUGS CHARGEABLE RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	139	0		1.00
2.00	OPERATION OF PLANT	7.00	0	4	0		2.00
3.00	NURSING ADMINISTRATION	13.00	0	1	0		3.00
4.00	PHARMACY	15.00	0	7,236,885	0		4.00
5.00	ADULTS & PEDIATRICS	30.00	0	3,049	0		5.00
6.00	INTENSIVE CARE UNIT	31.00	0	618	0		6.00
7.00	OPERATING ROOM	50.00	0	131	0		7.00
8.00	RADIOLOGY-DIAGNOSTIC	54.00	0	16,491	0		8.00
9.00	RESPIRATORY THERAPY	65.00	0	6,052	0		9.00
10.00	PHYSICAL THERAPY	66.00	0	5	0		10.00
11.00	ONCOLOGY	76.00	0	96,663	0		11.00

RECLASSIFICATIONS | Provider CCN: 15-0001 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-6 | Date/Time Prepared: 5/24/2023 9:39 am

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
12.00	CLINIC	90.00	0	74,639	0		12.00
13.00	EMERGENCY	91.00	0	80	0		13.00
14.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	494,820	0		14.00
	TOTALS		0	7,929,577			
500.00	Grand Total: Decreases		658,560	13,383,203			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0001 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-7 Part I | Date/Time Prepared: 5/24/2023 9:39 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	4,926,609	0	0	0	0	1.00
2.00	Land Improvements	2,727,617	368,602	0	368,602	0	2.00
3.00	Buildings and Fixtures	0	0	0	0	0	3.00
4.00	Building Improvements	67,759,440	37,781,659	0	37,781,659	0	4.00
5.00	Fixed Equipment	13,103,672	1,982,854	0	1,982,854	0	5.00
6.00	Movable Equipment	54,287,477	0	0	0	12,511,388	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	142,804,815	40,133,115	0	40,133,115	12,511,388	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	142,804,815	40,133,115	0	40,133,115	12,511,388	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	4,926,609	0	1.00
2.00	Land Improvements	3,096,219	0	2.00
3.00	Buildings and Fixtures	0	0	3.00
4.00	Building Improvements	105,541,099	0	4.00
5.00	Fixed Equipment	15,086,526	0	5.00
6.00	Movable Equipment	41,776,089	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	170,426,542	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	170,426,542	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0001 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-7 Part II Date/Time Prepared: 5/24/2023 9:39 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	NEW CAP REL COSTS-BLDG & FIXT	3,065,371	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	4,173,319	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	7,238,690	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	NEW CAP REL COSTS-BLDG & FIXT	0	3,065,371		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	4,173,319		2.00
3.00	Total (sum of lines 1-2)	0	7,238,690		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0001 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-7 Part III Date/Time Prepared: 5/24/2023 9:39 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	NEW CAP REL COSTS-BLDG & FIXT	170,426,542	0	170,426,542	1.000000	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0.000000	0	2.00
3.00	Total (sum of lines 1-2)	170,426,542	0	170,426,542	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	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	3,148,757	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	4,173,319	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	7,322,076	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	-171,949	0	0	0	2,976,808	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	4,173,319	2.00
3.00	Total (sum of lines 1-2)	-171,949	0	0	0	7,150,127	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0001 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-8 | Date/Time Prepared: 5/24/2023 9:39 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 - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-5,558,450			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests		0		0.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	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 - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0001 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-8 | Date/Time Prepared: 5/24/2023 9:39 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	
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	CAFETERIA CANTEEN VENDING REVENUE	B	-158,831	CAFETERIA	11.00	0	33.00
33.01	CAFETERIA CANTEEN VENDING REVENUE	B	0	CAFETERIA	11.00	0	33.01
33.02	MISC OTHER REVENUE	B	-10,518	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	MISC OTHER REVENUE	B	184	DIETARY	10.00	0	33.03
33.04	MISC OTHER REVENUE	B	0	NURSING ADMINISTRATION	13.00	0	33.04
33.05	MISC OTHER REVENUE	B	0	PHARMACY	15.00	0	33.05
33.06	MISC OTHER REVENUE	B	-48,750	MEDICAL RECORDS & LIBRARY	16.00	0	33.06
33.07	MISC OTHER REVENUE	B	-35,254	LABORATORY	60.00	0	33.07
33.08	MISC OTHER REVENUE	B	-1,292	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	33.08
33.09	MISC OTHER REVENUE	B	929	ONCOLOGY	76.00	0	33.09
33.10	MISC OTHER REVENUE	B	0	CLINIC	90.00	0	33.10
33.11	MISC OTHER REVENUE	B	0	MATERIALS MANAGEMENT	4.03	0	33.11
33.12	MISC OTHER REVENUE	B	6,134	NURSING ADMINISTRATION	13.00	0	33.12
33.13	CABLE SERVICES	A	-33,121	OPERATION OF PLANT	7.00	0	33.13
33.14	TELEPHONE SERVICES	A	-1,177	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	33.14
33.15	TELEPHONE SERVICES	A	-18,449	COMMUNICATIONS	4.01	0	33.15
33.16	COMMUNICATIONS	A	-18,756	COMMUNICATIONS	4.01	0	33.16
33.17	ADVERTISING EXP - A&G	A	-525,474	ADMINISTRATIVE & GENERAL	5.00	0	33.17
33.18	ADVERTISING EXP - PHYSICAL THERAPY	A	-123	PHYSICAL THERAPY	66.00	0	33.18
33.19	ADVERTISING EXP - CLINIC	A	0	CLINIC	90.00	0	33.19
33.20	ADVERTISING EXP - EMERGENCY ROOM	A	0	EMERGENCY	91.00	0	33.20
33.21	LOBBYING EXPENSE - AHA	A	-6,880	ADMINISTRATIVE & GENERAL	5.00	0	33.21
33.22	LOBBYING EXPENSE - IHA	A	-2,624	ADMINISTRATIVE & GENERAL	5.00	0	33.22
33.23	PROF - BUILDING-PLANT WORK ORDERS	A	-23,407	OPERATION OF PLANT	7.00	0	33.23
33.24	PROF - BUILDING-PLANT WORK ORDERS	A	-7,716	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.24
33.25	1993 AHA LIFE	A	84,563	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	33.25
33.26	HAF EXPENSE	A	-4,193,280	ADMINISTRATIVE & GENERAL	5.00	0	33.26
33.27	INTEREST EXPENSE	A	-171,949	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	33.27
33.28	ELECTROENCEPHALOGRAPHY OFFSET	A	0	ELECTROENCEPHALOGRAPHY	70.00	0	33.28
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-10,724,241				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.

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-0001 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-8-2 | Date/Time Prepared: 5/24/2023 9:39 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	2,231,821	2,231,821	0	211,500	0	1.00
2.00	53.00	ANESTHESIOLOGY	1,125,977	1,125,977	0	211,500	0	2.00
3.00	70.00	ELECTROENCEPHALOGRAPHY	100,000	100,000	0	211,500	0	3.00
4.00	76.00	ONCOLOGY	17,313	0	17,313	211,500	69	4.00
5.00	76.97	CARDIAC REHABILITATION	95,150	95,150	0	211,500	0	5.00
6.00	90.00	CLINIC	92,400	92,400	0	211,500	0	6.00
7.00	91.00	EMERGENCY	1,902,805	1,902,805	0	211,500	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			5,565,466	5,548,153	17,313		69	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	2.00
3.00	70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	3.00
4.00	76.00	ONCOLOGY	7,016	351	0	0	0	4.00
5.00	76.97	CARDIAC REHABILITATION	0	0	0	0	0	5.00
6.00	90.00	CLINIC	0	0	0	0	0	6.00
7.00	91.00	EMERGENCY	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			7,016	351	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	2,231,821		1.00
2.00	53.00	ANESTHESIOLOGY	0	0	0	1,125,977		2.00
3.00	70.00	ELECTROENCEPHALOGRAPHY	0	0	0	100,000		3.00
4.00	76.00	ONCOLOGY	0	7,016	10,297	10,297		4.00
5.00	76.97	CARDIAC REHABILITATION	0	0	0	95,150		5.00
6.00	90.00	CLINIC	0	0	0	92,400		6.00
7.00	91.00	EMERGENCY	0	0	0	1,902,805		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	7,016	10,297	5,558,450		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0001 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part I Date/Time Prepared: 5/24/2023 9:39 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	COMMUNICATIONS	
				NEW BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	4.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	2,976,808	2,976,808				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	4,173,319		4,173,319			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	11,053,004	36,161	1,859	11,091,024		4.00
4.01	00401	COMMUNICATIONS	350,599	4,763	0	25,201	380,563	4.01
4.02	00402	DATA PROCESSING	3,781,583	75,861	1,956,495	177,832	37,860	4.02
4.03	00403	MATERIALS MANAGEMENT	458,381	46,365	9,269	95,214	8,133	4.03
4.04	00404	ADMITTING	1,004,429	27,133	0	226,453	9,535	4.04
4.05	00405	PATIENT ACCOUNTING	1,618,030	80,587	16,360	208,899	24,679	4.05
5.00	00500	ADMINISTRATIVE & GENERAL	3,746,633	115,439	41,063	342,017	21,594	5.00
7.00	00700	OPERATION OF PLANT	4,576,930	408,836	62,984	219,509	13,742	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	202,245	29,132	6,935	26,521	1,402	8.00
9.00	00900	HOUSEKEEPING	829,656	22,625	6,240	169,641	3,926	9.00
10.00	01000	DIETARY	452,515	47,468	29,046	59,313	7,292	10.00
11.00	01100	CAFETERIA	442,744	50,546	0	81,308	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,256,924	119,572	45,783	257,711	12,900	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	89,812	20,589	46,179	20,070	0	14.00
15.00	01500	PHARMACY	1,693,128	24,794	7,806	228,530	6,450	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	844,948	47,007	11,278	150,093	10,376	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,890,387	334,187	209,777	1,431,734	34,495	30.00
31.00	03100	INTENSIVE CARE UNIT	2,607,437	95,565	49,813	255,884	7,852	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	269,193	7,574	0	53,403	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,892,566	554,546	623,766	522,578	24,679	50.00
53.00	05300	ANESTHESIOLOGY	1,131,770	4,775	19,862	225,430	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,248,467	200,340	480,669	532,668	14,583	54.00
60.00	06000	LABORATORY	5,890,544	97,540	197,624	453,973	19,070	60.00
65.00	06500	RESPIRATORY THERAPY	2,062,758	4,532	21,668	372,543	5,048	65.00
66.00	06600	PHYSICAL THERAPY	948,102	76,806	14,133	207,411	7,011	66.00
67.00	06700	OCCUPATIONAL THERAPY	301,671	16,178	3,340	69,334	1,683	67.00
68.00	06800	SPEECH PATHOLOGY	153,944	1,006	523	35,092	1,683	68.00
69.00	06900	ELECTROCARDIOLOGY	600,403	13,088	47,499	93,681	12,059	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	16,381	2,206	2,588	3,767	561	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,190,649	0	19,635	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	3,545,012	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,929,577	0	0	0	0	73.00
76.00	03020	ONCOLOGY	618,292	84,816	3,027	126,834	10,376	76.00
76.97	07697	CARDIAC REHABILITATION	201,184	30,429	14,454	38,866	0	76.97
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,154,217	139,555	23,115	186,962	5,889	90.00
91.00	09100	EMERGENCY	3,929,190	120,384	43,516	762,191	16,546	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	724,771	15,814	91	135,951	6,450	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)	86,858,203	2,956,219	4,016,397	7,796,614	325,874	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	210,492	15,717	6,245	42,411	4,207	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	16,989,378	0	149,917	3,233,592	45,995	192.00
192.01	19201	SOUTH CLINIC	0	0	0	0	0	192.01
192.02	19202	WEST CLINIC	0	0	0	0	0	192.02
192.03	19203	DIABETES CENTER	80,620	4,872	760	18,407	841	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	ADULT/CHILD CARE	0	0	0	0	1,402	193.01
193.02	19302	PHYSICIAN OFFICE BUILDING	875,607	0	0	0	0	193.02
193.03	19303	OPTIFAST/FOUNDATION	0	0	0	0	0	193.03
194.00	07950	PARTNERSHIP HFC	483	0	0	0	2,244	194.00
194.01	07951	TRAFALGAR CLINIC	0	0	0	0	0	194.01
194.02	07952	EDINBURGH	0	0	0	0	0	194.02
194.03	07953	JAIL	0	0	0	0	0	194.03
194.04	07954	ATHLETIC TRAINERS	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	105,014,783	2,976,808	4,173,319	11,091,024	380,563	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0001 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part I | Date/Time Prepared: 5/24/2023 9:39 am

		Cost Center Description	DATA PROCESSING	MATERIALS MANAGEMENT	ADMITTING	PATIENT ACCOUNTING	Subtotal	
			4.02	4.03	4.04	4.05	4A.05	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401	COMMUNICATIONS						4.01
4.02	00402	DATA PROCESSING	6,029,631					4.02
4.03	00403	MATERIALS MANAGEMENT	67,893	685,255				4.03
4.04	00404	ADMITTING	229,368	878	1,497,796			4.04
4.05	00405	PATIENT ACCOUNTING	403,688	289	0	2,352,532		4.05
5.00	00500	ADMINISTRATIVE & GENERAL	449,562	3,034	0	0	4,719,342	5.00
7.00	00700	OPERATION OF PLANT	78,903	47	0	0	5,360,951	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	58,718	119	0	0	325,072	8.00
9.00	00900	HOUSEKEEPING	0	392	0	0	1,032,480	9.00
10.00	01000	DIETARY	51,378	10,938	0	0	657,950	10.00
11.00	01100	CAFETERIA	0	0	0	0	574,598	11.00
13.00	01300	NURSING ADMINISTRATION	141,291	4,146	0	0	1,838,327	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	2,271	0	0	178,921	14.00
15.00	01500	PHARMACY	170,650	274,473	0	0	2,405,831	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	148,631	166	0	0	1,212,499	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	350,475	12,558	68,948	108,292	8,440,853	30.00
31.00	03100	INTENSIVE CARE UNIT	172,485	3,921	17,234	27,068	3,237,259	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	0	0	2,707	4,251	337,128	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	594,522	16,148	209,703	329,364	5,767,872	50.00
53.00	05300	ANESTHESIOLOGY	0	21	32,052	50,342	1,464,252	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	205,514	7,564	331,812	521,209	5,542,826	54.00
60.00	06000	LABORATORY	249,553	92,422	228,732	359,252	7,588,710	60.00
65.00	06500	RESPIRATORY THERAPY	135,786	7,065	34,789	54,641	2,698,830	65.00
66.00	06600	PHYSICAL THERAPY	77,068	752	18,987	29,822	1,380,092	66.00
67.00	06700	OCCUPATIONAL THERAPY	20,184	0	5,512	8,658	426,560	67.00
68.00	06800	SPEECH PATHOLOGY	14,680	41	2,387	3,749	213,105	68.00
69.00	06900	ELECTROCARDIOLOGY	62,388	454	23,847	37,454	890,873	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	12	656	1,030	27,201	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	159,572	55,845	87,711	2,513,412	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	43,519	68,351	3,656,882	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	154,634	242,872	8,327,083	73.00
76.00	03020	ONCOLOGY	198,174	4,699	7,470	11,733	1,065,421	76.00
76.97	07697	CARDIAC REHABILITATION	0	460	3,365	5,285	294,043	76.97
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	289,921	9,450	61,045	95,879	2,966,033	90.00
91.00	09100	EMERGENCY	308,271	14,928	192,704	302,666	5,690,396	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	64,223	309	1,848	2,903	952,360	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)	4,543,326	627,129	1,497,796	2,352,532	81,787,162	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	64,223	541	0	0	343,836	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,374,373	57,568	0	0	21,850,823	192.00
192.01	19201	SOUTH CLINIC	0	0	0	0	0	192.01
192.02	19202	WEST CLINIC	0	0	0	0	0	192.02
192.03	19203	DIABETES CENTER	14,680	17	0	0	120,197	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	ADULT/CHILD CARE	0	0	0	0	1,402	193.01
193.02	19302	PHYSICIAN OFFICE BUILDING	0	0	0	0	875,607	193.02
193.03	19303	OPTIFAST/FOUNDATION	0	0	0	0	0	193.03
194.00	07950	PARTNERSHIP HFC	33,029	0	0	0	35,756	194.00
194.01	07951	TRAFALGAR CLINIC	0	0	0	0	0	194.01
194.02	07952	EDINBURGH	0	0	0	0	0	194.02
194.03	07953	JAIL	0	0	0	0	0	194.03
194.04	07954	ATHLETIC TRAINERS	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	6,029,631	685,255	1,497,796	2,352,532	105,014,783	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0001 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part I Date/Time Prepared: 5/24/2023 9:39 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401	COMMUNICATIONS						4.01
4.02	00402	DATA PROCESSING						4.02
4.03	00403	MATERIALS MANAGEMENT						4.03
4.04	00404	ADMITTING						4.04
4.05	00405	PATIENT ACCOUNTING						4.05
5.00	00500	ADMINISTRATIVE & GENERAL	4,719,342					5.00
7.00	00700	OPERATION OF PLANT	252,254	5,613,205				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	15,296	74,955	415,323			8.00
9.00	00900	HOUSEKEEPING	48,582	58,212	69,088	1,208,362		9.00
10.00	01000	DIETARY	30,959	122,129	6,844	26,930	844,812	10.00
11.00	01100	CAFETERIA	27,037	130,049	0	28,676	0	11.00
13.00	01300	NURSING ADMINISTRATION	86,501	307,646	0	67,837	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	8,419	52,974	0	11,681	0	14.00
15.00	01500	PHARMACY	113,204	63,793	0	14,066	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	57,053	120,944	0	26,669	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	397,176	859,831	124,473	189,595	760,427	30.00
31.00	03100	INTENSIVE CARE UNIT	152,326	245,880	31,962	54,217	84,385	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	15,863	19,487	0	4,297	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	271,401	1,426,792	55,615	314,612	0	50.00
53.00	05300	ANESTHESIOLOGY	68,899	12,285	0	2,709	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	260,812	515,456	22,363	113,659	0	54.00
60.00	06000	LABORATORY	357,079	250,962	0	55,338	0	60.00
65.00	06500	RESPIRATORY THERAPY	126,991	11,661	0	2,571	0	65.00
66.00	06600	PHYSICAL THERAPY	64,939	197,614	5,504	43,574	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	20,071	41,624	0	9,178	0	67.00
68.00	06800	SPEECH PATHOLOGY	10,027	2,588	0	571	0	68.00
69.00	06900	ELECTROCARDIOLOGY	41,919	33,674	2,077	7,425	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,280	5,675	0	1,251	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	118,266	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	172,071	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	391,823	0	0	0	0	73.00
76.00	03020	ONCOLOGY	50,132	218,224	0	48,119	0	76.00
76.97	07697	CARDIAC REHABILITATION	13,836	78,291	0	17,263	0	76.97
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	139,564	359,061	1,391	79,174	0	90.00
91.00	09100	EMERGENCY	267,756	309,735	91,924	68,297	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	44,812	40,689	0	8,972	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)	3,626,348	5,560,231	411,241	1,196,681	844,812	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	16,179	40,440	0	8,917	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,028,210	0	4,082	0	0	192.00
192.01	19201	SOUTH CLINIC	0	0	0	0	0	192.01
192.02	19202	WEST CLINIC	0	0	0	0	0	192.02
192.03	19203	DIABETES CENTER	5,656	12,534	0	2,764	0	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	ADULT/CHILD CARE	66	0	0	0	0	193.01
193.02	19302	PHYSICIAN OFFICE BUILDING	41,201	0	0	0	0	193.02
193.03	19303	OPTIFAST/FOUNDATION	0	0	0	0	0	193.03
194.00	07950	PARTNERSHIP HFC	1,682	0	0	0	0	194.00
194.01	07951	TRAFALGAR CLINIC	0	0	0	0	0	194.01
194.02	07952	EDINBURGH	0	0	0	0	0	194.02
194.03	07953	JAIL	0	0	0	0	0	194.03
194.04	07954	ATHLETIC TRAINERS	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	4,719,342	5,613,205	415,323	1,208,362	844,812	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0001 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part I | Date/Time Prepared: 5/24/2023 9:39 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401	COMMUNICATIONS						4.01
4.02	00402	DATA PROCESSING						4.02
4.03	00403	MATERIALS MANAGEMENT						4.03
4.04	00404	ADMITTING						4.04
4.05	00405	PATIENT ACCOUNTING						4.05
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	760,360					11.00
13.00	01300	NURSING ADMINISTRATION	22,788	2,323,099				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	5,047	0	257,042			14.00
15.00	01500	PHARMACY	25,919	0	0	2,622,813		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	32,950	0	0	0	1,450,115	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	121,337	1,011,213	0	0	66,758	30.00
31.00	03100	INTENSIVE CARE UNIT	38,698	274,182	0	0	16,686	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	21,387	0	0	0	2,621	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	73,867	523,361	0	0	203,040	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	31,034	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	69,922	0	0	0	321,175	54.00
60.00	06000	LABORATORY	87,572	0	0	0	221,465	60.00
65.00	06500	RESPIRATORY THERAPY	36,533	0	0	0	33,684	65.00
66.00	06600	PHYSICAL THERAPY	26,865	0	0	0	18,384	66.00
67.00	06700	OCCUPATIONAL THERAPY	7,631	0	0	0	5,337	67.00
68.00	06800	SPEECH PATHOLOGY	4,022	0	0	0	2,311	68.00
69.00	06900	ELECTROCARDIOLOGY	14,332	0	0	0	23,089	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	534	0	0	0	635	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	257,042	0	54,070	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	42,136	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	2,622,813	149,721	73.00
76.00	03020	ONCOLOGY	17,885	0	0	0	7,233	76.00
76.97	07697	CARDIAC REHABILITATION	4,977	0	0	0	3,258	76.97
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	44,433	0	0	0	59,106	90.00
91.00	09100	EMERGENCY	72,595	514,343	0	0	186,582	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	16,542	0	0	0	1,790	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)	745,836	2,323,099	257,042	2,622,813	1,450,115	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	14,524	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	SOUTH CLINIC	0	0	0	0	0	192.01
192.02	19202	WEST CLINIC	0	0	0	0	0	192.02
192.03	19203	DIABETES CENTER	0	0	0	0	0	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	ADULT/CHILD CARE	0	0	0	0	0	193.01
193.02	19302	PHYSICIAN OFFICE BUILDING	0	0	0	0	0	193.02
193.03	19303	OPTIFAST/FOUNDATION	0	0	0	0	0	193.03
194.00	07950	PARTNERSHIP HFC	0	0	0	0	0	194.00
194.01	07951	TRAFALGAR CLINIC	0	0	0	0	0	194.01
194.02	07952	EDINBURGH	0	0	0	0	0	194.02
194.03	07953	JAIL	0	0	0	0	0	194.03
194.04	07954	ATHLETIC TRAINERS	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	760,360	2,323,099	257,042	2,622,813	1,450,115	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0001 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part I | Date/Time Prepared: 5/24/2023 9:39 am

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
4.01	00401	COMMUNICATIONS					4.01
4.02	00402	DATA PROCESSING					4.02
4.03	00403	MATERIALS MANAGEMENT					4.03
4.04	00404	ADMITTING					4.04
4.05	00405	PATIENT ACCOUNTING					4.05
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	11,971,663	0	11,971,663		30.00
31.00	03100	INTENSIVE CARE UNIT	4,135,595	0	4,135,595		31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0		41.00
43.00	04300	NURSERY	400,783	0	400,783		43.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	8,636,560	0	8,636,560		50.00
53.00	05300	ANESTHESIOLOGY	1,579,179	0	1,579,179		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,846,213	0	6,846,213		54.00
60.00	06000	LABORATORY	8,561,126	0	8,561,126		60.00
65.00	06500	RESPIRATORY THERAPY	2,910,270	0	2,910,270		65.00
66.00	06600	PHYSICAL THERAPY	1,736,972	0	1,736,972		66.00
67.00	06700	OCCUPATIONAL THERAPY	510,401	0	510,401		67.00
68.00	06800	SPEECH PATHOLOGY	232,624	0	232,624		68.00
69.00	06900	ELECTROCARDIOLOGY	1,013,389	0	1,013,389		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	36,576	0	36,576		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,942,790	0	2,942,790		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	3,871,089	0	3,871,089		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	11,491,440	0	11,491,440		73.00
76.00	03020	ONCOLOGY	1,407,014	0	1,407,014		76.00
76.97	07697	CARDIAC REHABILITATION	411,668	0	411,668		76.97
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0		77.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	3,648,762	0	3,648,762		90.00
91.00	09100	EMERGENCY	7,201,628	0	7,201,628		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	1,065,165	0	1,065,165		101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0		102.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	80,610,907	0	80,610,907		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	423,896	0	423,896		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	22,883,115	0	22,883,115		192.00
192.01	19201	SOUTH CLINIC	0	0	0		192.01
192.02	19202	WEST CLINIC	0	0	0		192.02
192.03	19203	DIABETES CENTER	141,151	0	141,151		192.03
193.00	19300	NONPAID WORKERS	0	0	0		193.00
193.01	19301	ADULT/CHILD CARE	1,468	0	1,468		193.01
193.02	19302	PHYSICIAN OFFICE BUILDING	916,808	0	916,808		193.02
193.03	19303	OPTIFAST/FOUNDATION	0	0	0		193.03
194.00	07950	PARTNERSHIP HFC	37,438	0	37,438		194.00
194.01	07951	TRAFALGAR CLINIC	0	0	0		194.01
194.02	07952	EDINBURGH	0	0	0		194.02
194.03	07953	JAIL	0	0	0		194.03
194.04	07954	ATHLETIC TRAINERS	0	0	0		194.04
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	105,014,783	0	105,014,783		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0001 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part II | Date/Time Prepared: 5/24/2023 9:39 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW 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	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	36,161	1,859	38,020	38,020	4.00
4.01	00401	COMMUNICATIONS	0	4,763	0	4,763	86	4.01
4.02	00402	DATA PROCESSING	0	75,861	1,956,495	2,032,356	609	4.02
4.03	00403	MATERIALS MANAGEMENT	0	46,365	9,269	55,634	326	4.03
4.04	00404	ADMITTING	0	27,133	0	27,133	776	4.04
4.05	00405	PATIENT ACCOUNTING	0	80,587	16,360	96,947	716	4.05
5.00	00500	ADMINISTRATIVE & GENERAL	0	115,439	41,063	156,502	1,172	5.00
7.00	00700	OPERATION OF PLANT	0	408,836	62,984	471,820	752	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	29,132	6,935	36,067	91	8.00
9.00	00900	HOUSEKEEPING	0	22,625	6,240	28,865	581	9.00
10.00	01000	DIETARY	0	47,468	29,046	76,514	203	10.00
11.00	01100	CAFETERIA	0	50,546	0	50,546	279	11.00
13.00	01300	NURSING ADMINISTRATION	0	119,572	45,783	165,355	883	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	20,589	46,179	66,768	69	14.00
15.00	01500	PHARMACY	0	24,794	7,806	32,600	783	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	47,007	11,278	58,285	514	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	334,187	209,777	543,964	4,906	30.00
31.00	03100	INTENSIVE CARE UNIT	0	95,565	49,813	145,378	877	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	0	7,574	0	7,574	183	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	554,546	623,766	1,178,312	1,791	50.00
53.00	05300	ANESTHESIOLOGY	0	4,775	19,862	24,637	772	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	200,340	480,669	681,009	1,825	54.00
60.00	06000	LABORATORY	0	97,540	197,624	295,164	1,556	60.00
65.00	06500	RESPIRATORY THERAPY	0	4,532	21,668	26,200	1,277	65.00
66.00	06600	PHYSICAL THERAPY	0	76,806	14,133	90,939	711	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	16,178	3,340	19,518	238	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,006	523	1,529	120	68.00
69.00	06900	ELECTROCARDIOLOGY	0	13,088	47,499	60,587	321	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	2,206	2,588	4,794	13	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	19,635	19,635	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	ONCOLOGY	0	84,816	3,027	87,843	435	76.00
76.97	07697	CARDIAC REHABILITATION	0	30,429	14,454	44,883	133	76.97
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	139,555	23,115	162,670	641	90.00
91.00	09100	EMERGENCY	0	120,384	43,516	163,900	2,612	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	15,814	91	15,905	466	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)	0	2,956,219	4,016,397	6,972,616	26,717	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	15,717	6,245	21,962	145	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	149,917	149,917	11,095	192.00
192.01	19201	SOUTH CLINIC	0	0	0	0	0	192.01
192.02	19202	WEST CLINIC	0	0	0	0	0	192.02
192.03	19203	DIABETES CENTER	0	4,872	760	5,632	63	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	ADULT/CHILD CARE	0	0	0	0	0	193.01
193.02	19302	PHYSICIAN OFFICE BUILDING	0	0	0	0	0	193.02
193.03	19303	OPTIFAST/FOUNDATION	0	0	0	0	0	193.03
194.00	07950	PARTNERSHIP HFC	0	0	0	0	0	194.00
194.01	07951	TRAFALGAR CLINIC	0	0	0	0	0	194.01
194.02	07952	EDINBURGH	0	0	0	0	0	194.02
194.03	07953	JAIL	0	0	0	0	0	194.03
194.04	07954	ATHLETIC TRAINERS	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	2,976,808	4,173,319	7,150,127	38,020	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0001 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part II Date/Time Prepared: 5/24/2023 9:39 am

		Cost Center Description	COMMUNICATIONS	DATA PROCESSING	MATERIALS MANAGEMENT	ADMITTING	PATIENT ACCOUNTING	
			4.01	4.02	4.03	4.04	4.05	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401	COMMUNICATIONS	4,849					4.01
4.02	00402	DATA PROCESSING	482	2,033,447				4.02
4.03	00403	MATERIALS MANAGEMENT	104	22,896	78,960			4.03
4.04	00404	ADMITTING	121	77,353	101	105,484		4.04
4.05	00405	PATIENT ACCOUNTING	314	136,141	33	0	234,151	4.05
5.00	00500	ADMINISTRATIVE & GENERAL	275	151,611	350	0	0	5.00
7.00	00700	OPERATION OF PLANT	175	26,609	5	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	18	19,802	14	0	0	8.00
9.00	00900	HOUSEKEEPING	50	0	45	0	0	9.00
10.00	01000	DIETARY	93	17,327	1,260	0	0	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	164	47,649	478	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	262	0	0	14.00
15.00	01500	PHARMACY	82	57,550	31,633	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	132	50,125	19	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	440	118,195	1,447	4,853	10,784	30.00
31.00	03100	INTENSIVE CARE UNIT	100	58,169	452	1,213	2,695	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	0	0	0	190	423	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	314	200,498	1,860	14,759	32,798	50.00
53.00	05300	ANESTHESIOLOGY	0	0	2	2,256	5,013	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	186	69,308	871	23,422	51,790	54.00
60.00	06000	LABORATORY	243	84,160	10,648	16,098	35,774	60.00
65.00	06500	RESPIRATORY THERAPY	64	45,793	814	2,449	5,441	65.00
66.00	06600	PHYSICAL THERAPY	89	25,990	87	1,336	2,970	66.00
67.00	06700	OCCUPATIONAL THERAPY	21	6,807	0	388	862	67.00
68.00	06800	SPEECH PATHOLOGY	21	4,951	5	168	373	68.00
69.00	06900	ELECTROCARDIOLOGY	154	21,040	52	1,678	3,730	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	7	0	1	46	103	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	18,385	3,930	8,734	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	3,063	6,806	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	10,883	24,185	73.00
76.00	03020	ONCOLOGY	132	66,833	541	526	1,168	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	53	237	526	76.97
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	75	97,774	1,089	4,296	9,548	90.00
91.00	09100	EMERGENCY	211	103,962	1,720	13,563	30,139	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	82	21,659	36	130	289	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)	4,149	1,532,202	72,263	105,484	234,151	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	54	21,659	62	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	588	463,496	6,633	0	0	192.00
192.01	19201	SOUTH CLINIC	0	0	0	0	0	192.01
192.02	19202	WEST CLINIC	0	0	0	0	0	192.02
192.03	19203	DIABETES CENTER	11	4,951	2	0	0	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	ADULT/CHILD CARE	18	0	0	0	0	193.01
193.02	19302	PHYSICIAN OFFICE BUILDING	0	0	0	0	0	193.02
193.03	19303	OPTIFAST/FOUNDATION	0	0	0	0	0	193.03
194.00	07950	PARTNERSHIP HFC	29	11,139	0	0	0	194.00
194.01	07951	TRAFALGAR CLINIC	0	0	0	0	0	194.01
194.02	07952	EDINBURGH	0	0	0	0	0	194.02
194.03	07953	JAIL	0	0	0	0	0	194.03
194.04	07954	ATHLETIC TRAINERS	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	4,849	2,033,447	78,960	105,484	234,151	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0001 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part II | Date/Time Prepared: 5/24/2023 9:39 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401	COMMUNICATIONS						4.01
4.02	00402	DATA PROCESSING						4.02
4.03	00403	MATERIALS MANAGEMENT						4.03
4.04	00404	ADMITTING						4.04
4.05	00405	PATIENT ACCOUNTING						4.05
5.00	00500	ADMINISTRATIVE & GENERAL	309,910					5.00
7.00	00700	OPERATION OF PLANT	16,565	515,926				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,004	6,889	63,885			8.00
9.00	00900	HOUSEKEEPING	3,190	5,350	10,627	48,708		9.00
10.00	01000	DIETARY	2,033	11,225	1,053	1,086	110,794	10.00
11.00	01100	CAFETERIA	1,776	11,953	0	1,156	0	11.00
13.00	01300	NURSING ADMINISTRATION	5,680	28,277	0	2,734	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	553	4,869	0	471	0	14.00
15.00	01500	PHARMACY	7,434	5,863	0	567	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,747	11,116	0	1,075	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	26,082	79,030	19,146	7,642	99,727	30.00
31.00	03100	INTENSIVE CARE UNIT	10,003	22,600	4,916	2,185	11,067	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	1,042	1,791	0	173	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	17,823	131,140	8,555	12,684	0	50.00
53.00	05300	ANESTHESIOLOGY	4,525	1,129	0	109	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	17,127	47,377	3,440	4,581	0	54.00
60.00	06000	LABORATORY	23,449	23,067	0	2,231	0	60.00
65.00	06500	RESPIRATORY THERAPY	8,339	1,072	0	104	0	65.00
66.00	06600	PHYSICAL THERAPY	4,264	18,163	847	1,756	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,318	3,826	0	370	0	67.00
68.00	06800	SPEECH PATHOLOGY	658	238	0	23	0	68.00
69.00	06900	ELECTROCARDIOLOGY	2,753	3,095	319	299	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	84	522	0	50	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	7,766	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	11,300	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	25,731	0	0	0	0	73.00
76.00	03020	ONCOLOGY	3,292	20,058	0	1,940	0	76.00
76.97	07697	CARDIAC REHABILITATION	909	7,196	0	696	0	76.97
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	9,165	33,002	214	3,191	0	90.00
91.00	09100	EMERGENCY	17,583	28,469	14,140	2,753	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	2,943	3,740	0	362	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)	238,138	511,057	63,257	48,238	110,794	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,062	3,717	0	359	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	67,519	0	628	0	0	192.00
192.01	19201	SOUTH CLINIC	0	0	0	0	0	192.01
192.02	19202	WEST CLINIC	0	0	0	0	0	192.02
192.03	19203	DIABETES CENTER	371	1,152	0	111	0	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	ADULT/CHILD CARE	4	0	0	0	0	193.01
193.02	19302	PHYSICIAN OFFICE BUILDING	2,706	0	0	0	0	193.02
193.03	19303	OPTIFAST/FOUNDATION	0	0	0	0	0	193.03
194.00	07950	PARTNERSHIP HFC	110	0	0	0	0	194.00
194.01	07951	TRAFALGAR CLINIC	0	0	0	0	0	194.01
194.02	07952	EDINBURGH	0	0	0	0	0	194.02
194.03	07953	JAIL	0	0	0	0	0	194.03
194.04	07954	ATHLETIC TRAINERS	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	309,910	515,926	63,885	48,708	110,794	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0001 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part II Date/Time Prepared: 5/24/2023 9:39 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401	COMMUNICATIONS						4.01
4.02	00402	DATA PROCESSING						4.02
4.03	00403	MATERIALS MANAGEMENT						4.03
4.04	00404	ADMITTING						4.04
4.05	00405	PATIENT ACCOUNTING						4.05
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	65,710					11.00
13.00	01300	NURSING ADMINISTRATION	1,969	253,189				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	436	0	73,428			14.00
15.00	01500	PHARMACY	2,240	0	0	138,752		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,848	0	0	0	127,861	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	10,484	110,210	0	0	5,880	30.00
31.00	03100	INTENSIVE CARE UNIT	3,344	29,882	0	0	1,470	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	1,848	0	0	0	231	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,384	57,040	0	0	17,885	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	2,734	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,043	0	0	0	28,417	54.00
60.00	06000	LABORATORY	7,568	0	0	0	19,508	60.00
65.00	06500	RESPIRATORY THERAPY	3,157	0	0	0	2,967	65.00
66.00	06600	PHYSICAL THERAPY	2,322	0	0	0	1,619	66.00
67.00	06700	OCCUPATIONAL THERAPY	659	0	0	0	470	67.00
68.00	06800	SPEECH PATHOLOGY	348	0	0	0	204	68.00
69.00	06900	ELECTROCARDIOLOGY	1,239	0	0	0	2,034	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	46	0	0	0	56	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	73,428	0	4,763	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	3,712	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	138,752	13,188	73.00
76.00	03020	ONCOLOGY	1,546	0	0	0	637	76.00
76.97	07697	CARDIAC REHABILITATION	430	0	0	0	287	76.97
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	3,840	0	0	0	5,206	90.00
91.00	09100	EMERGENCY	6,274	56,057	0	0	16,435	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,430	0	0	0	158	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)	64,455	253,189	73,428	138,752	127,861	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,255	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	SOUTH CLINIC	0	0	0	0	0	192.01
192.02	19202	WEST CLINIC	0	0	0	0	0	192.02
192.03	19203	DIABETES CENTER	0	0	0	0	0	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	ADULT/CHILD CARE	0	0	0	0	0	193.01
193.02	19302	PHYSICIAN OFFICE BUILDING	0	0	0	0	0	193.02
193.03	19303	OPTIFAST/FOUNDATION	0	0	0	0	0	193.03
194.00	07950	PARTNERSHIP HFC	0	0	0	0	0	194.00
194.01	07951	TRAFALGAR CLINIC	0	0	0	0	0	194.01
194.02	07952	EDINBURGH	0	0	0	0	0	194.02
194.03	07953	JAIL	0	0	0	0	0	194.03
194.04	07954	ATHLETIC TRAINERS	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	65,710	253,189	73,428	138,752	127,861	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0001 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part II | Date/Time Prepared: 5/24/2023 9:39 am

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
4.01	00401	COMMUNICATIONS					4.01
4.02	00402	DATA PROCESSING					4.02
4.03	00403	MATERIALS MANAGEMENT					4.03
4.04	00404	ADMITTING					4.04
4.05	00405	PATIENT ACCOUNTING					4.05
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	1,042,790	0	1,042,790		30.00
31.00	03100	INTENSIVE CARE UNIT	294,351	0	294,351		31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0		41.00
43.00	04300	NURSERY	13,455	0	13,455		43.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	1,681,843	0	1,681,843		50.00
53.00	05300	ANESTHESIOLOGY	41,177	0	41,177		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	935,396	0	935,396		54.00
60.00	06000	LABORATORY	519,466	0	519,466		60.00
65.00	06500	RESPIRATORY THERAPY	97,677	0	97,677		65.00
66.00	06600	PHYSICAL THERAPY	151,093	0	151,093		66.00
67.00	06700	OCCUPATIONAL THERAPY	34,477	0	34,477		67.00
68.00	06800	SPEECH PATHOLOGY	8,638	0	8,638		68.00
69.00	06900	ELECTROCARDIOLOGY	97,301	0	97,301		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	5,722	0	5,722		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	136,641	0	136,641		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	24,881	0	24,881		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	212,739	0	212,739		73.00
76.00	03020	ONCOLOGY	184,951	0	184,951		76.00
76.97	07697	CARDIAC REHABILITATION	55,350	0	55,350		76.97
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0		77.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	330,711	0	330,711		90.00
91.00	09100	EMERGENCY	457,818	0	457,818		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	47,200	0	47,200		101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0		102.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	6,373,677	0	6,373,677		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	50,275	0	50,275		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	699,876	0	699,876		192.00
192.01	19201	SOUTH CLINIC	0	0	0		192.01
192.02	19202	WEST CLINIC	0	0	0		192.02
192.03	19203	DIABETES CENTER	12,293	0	12,293		192.03
193.00	19300	NONPAID WORKERS	0	0	0		193.00
193.01	19301	ADULT/CHILD CARE	22	0	22		193.01
193.02	19302	PHYSICIAN OFFICE BUILDING	2,706	0	2,706		193.02
193.03	19303	OPTIFAST/FOUNDATION	0	0	0		193.03
194.00	07950	PARTNERSHIP HFC	11,278	0	11,278		194.00
194.01	07951	TRAFALGAR CLINIC	0	0	0		194.01
194.02	07952	EDINBURGH	0	0	0		194.02
194.03	07953	JAIL	0	0	0		194.03
194.04	07954	ATHLETIC TRAINERS	0	0	0		194.04
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	7,150,127	0	7,150,127		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0001 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B-1 | Date/Time Prepared: 5/24/2023 9:39 am

		Cost Center Description	CAPITAL RELATED COSTS					
			NEW BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	COMMUNICATIONS (# NON PT PHONES)	DATA PROCESSING (WORK ORDERS)	
			1.00	2.00	4.00	4.01	4.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	245,645					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2,575,451				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,984	1,147	48,231,246			4.00
4.01	00401	COMMUNICATIONS	393	0	109,593	1,357		4.01
4.02	00402	DATA PROCESSING	6,260	1,207,398	773,334	135	3,286	4.02
4.03	00403	MATERIALS MANAGEMENT	3,826	5,720	414,053	29	37	4.03
4.04	00404	ADMITTING	2,239	0	984,769	34	125	4.04
4.05	00405	PATIENT ACCOUNTING	6,650	10,096	908,434	88	220	4.05
5.00	00500	ADMINISTRATIVE & GENERAL	9,526	25,341	1,487,322	77	245	5.00
7.00	00700	OPERATION OF PLANT	33,737	38,869	954,575	49	43	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,404	4,280	115,332	5	32	8.00
9.00	00900	HOUSEKEEPING	1,867	3,851	737,716	14	0	9.00
10.00	01000	DIETARY	3,917	17,925	257,933	26	28	10.00
11.00	01100	CAFETERIA	4,171	0	353,584	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	9,867	28,254	1,120,702	46	77	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,699	28,498	87,276	0	0	14.00
15.00	01500	PHARMACY	2,046	4,817	993,803	23	93	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,879	6,960	652,706	37	81	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	27,577	129,458	6,226,148	123	191	30.00
31.00	03100	INTENSIVE CARE UNIT	7,886	30,741	1,112,759	28	94	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	625	0	232,234	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	45,761	384,940	2,272,525	88	324	50.00
53.00	05300	ANESTHESIOLOGY	394	12,257	980,323	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	16,532	296,632	2,316,400	52	112	54.00
60.00	06000	LABORATORY	8,049	121,958	1,974,182	68	136	60.00
65.00	06500	RESPIRATORY THERAPY	374	13,372	1,620,068	18	74	65.00
66.00	06600	PHYSICAL THERAPY	6,338	8,722	901,964	25	42	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,335	2,061	301,511	6	11	67.00
68.00	06800	SPEECH PATHOLOGY	83	323	152,602	6	8	68.00
69.00	06900	ELECTROCARDIOLOGY	1,080	29,313	407,388	43	34	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	182	1,597	16,381	2	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	12,117	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	ONCOLOGY	6,999	1,868	551,559	37	108	76.00
76.97	07697	CARDIAC REHABILITATION	2,511	8,920	169,014	0	0	76.97
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	11,516	14,265	813,037	21	158	90.00
91.00	09100	EMERGENCY	9,934	26,855	3,314,522	59	168	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,305	56	591,206	23	35	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)	243,946	2,478,611	33,904,955	1,162	2,476	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,297	3,854	184,431	15	35	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	92,517	14,061,813	164	749	192.00
192.01	19201	SOUTH CLINIC	0	0	0	0	0	192.01
192.02	19202	WEST CLINIC	0	0	0	0	0	192.02
192.03	19203	DIABETES CENTER	402	469	80,047	3	8	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	ADULT/CHILD CARE	0	0	0	5	0	193.01
193.02	19302	PHYSICIAN OFFICE BUILDING	0	0	0	0	0	193.02
193.03	19303	OPTIFAST/FOUNDATION	0	0	0	0	0	193.03
194.00	07950	PARTNERSHIP HFC	0	0	0	8	18	194.00
194.01	07951	TRAFALGAR CLINIC	0	0	0	0	0	194.01
194.02	07952	EDINBURGH	0	0	0	0	0	194.02
194.03	07953	JAIL	0	0	0	0	0	194.03
194.04	07954	ATHLETIC TRAINERS	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0001 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B-1 | Date/Time Prepared: 5/24/2023 9:39 am

		Cost Center Description	CAPITAL RELATED COSTS					
			NEW BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	COMMUNICATIONS (# NON PT PHONES)	DATA PROCESSING (WORK ORDERS)	
			1.00	2.00	4.00	4.01	4.02	
202.00		Cost to be allocated (per Wkst. B, Part I)	2,976,808	4,173,319	11,091,024	380,563	6,029,631	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	12.118333	1.620423	0.229955	280.444363	1,834.945526	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			38,020	4,849	2,033,447	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000788	3.573324	618.821363	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: 15-0001 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B-1 | Date/Time Prepared: 5/24/2023 9:39 am

		Cost Center Description	MATERIALS MANAGEMENT (SUPPLY USAGE)	ADMITTING (GROSS CHARGES)	PATIENT ACCOUNTING (GROSS CHARGES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			4.03	4.04	4.05	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401	COMMUNICATIONS						4.01
4.02	00402	DATA PROCESSING						4.02
4.03	00403	MATERIALS MANAGEMENT	18,259,077					4.03
4.04	00404	ADMITTING	23,396	366,025,037				4.04
4.05	00405	PATIENT ACCOUNTING	7,693	0	366,025,037			4.05
5.00	00500	ADMINISTRATIVE & GENERAL	80,851	0	0	-4,719,342	100,295,441	5.00
7.00	00700	OPERATION OF PLANT	1,254	0	0	0	5,360,951	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,173	0	0	0	325,072	8.00
9.00	00900	HOUSEKEEPING	10,440	0	0	0	1,032,480	9.00
10.00	01000	DIETARY	291,447	0	0	0	657,950	10.00
11.00	01100	CAFETERIA	0	0	0	0	574,598	11.00
13.00	01300	NURSING ADMINISTRATION	110,473	0	0	0	1,838,327	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	60,522	0	0	0	178,921	14.00
15.00	01500	PHARMACY	7,313,665	0	0	0	2,405,831	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,421	0	0	0	1,212,499	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	334,615	16,849,537	16,849,537	0	8,440,853	30.00
31.00	03100	INTENSIVE CARE UNIT	104,475	4,211,590	4,211,590	0	3,237,259	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	0	661,446	661,446	0	337,128	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	430,262	51,246,954	51,246,954	0	5,767,872	50.00
53.00	05300	ANESTHESIOLOGY	560	7,832,927	7,832,927	0	1,464,252	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	201,533	81,082,739	81,082,739	0	5,542,826	54.00
60.00	06000	LABORATORY	2,462,605	55,897,253	55,897,253	0	7,588,710	60.00
65.00	06500	RESPIRATORY THERAPY	188,239	8,501,791	8,501,791	0	2,698,830	65.00
66.00	06600	PHYSICAL THERAPY	20,036	4,640,126	4,640,126	0	1,380,092	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,347,108	1,347,108	0	426,560	67.00
68.00	06800	SPEECH PATHOLOGY	1,092	583,289	583,289	0	213,105	68.00
69.00	06900	ELECTROCARDIOLOGY	12,090	5,827,662	5,827,662	0	890,873	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	318	160,289	160,289	0	27,201	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,251,855	13,647,246	13,647,246	0	2,513,412	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	10,635,036	10,635,036	0	3,656,882	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	37,789,342	37,789,342	0	8,327,083	73.00
76.00	03020	ONCOLOGY	125,199	1,825,622	1,825,622	0	1,065,421	76.00
76.97	07697	CARDIAC REHABILITATION	12,256	822,245	822,245	0	294,043	76.97
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	251,805	14,918,205	14,918,205	0	2,966,033	90.00
91.00	09100	EMERGENCY	397,758	47,092,950	47,092,950	0	5,690,396	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	8,237	451,680	451,680	0	952,360	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)	16,710,270	366,025,037	366,025,037	-4,719,342	77,067,820	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	14,418	0	0	0	343,836	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,533,927	0	0	0	21,850,823	192.00
192.01	19201	SOUTH CLINIC	0	0	0	0	0	192.01
192.02	19202	WEST CLINIC	0	0	0	0	0	192.02
192.03	19203	DIABETES CENTER	453	0	0	0	120,197	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	ADULT/CHILD CARE	0	0	0	0	1,402	193.01
193.02	19302	PHYSICIAN OFFICE BUILDING	9	0	0	0	875,607	193.02
193.03	19303	OPTIFAST/FOUNDATION	0	0	0	0	0	193.03
194.00	07950	PARTNERSHIP HFC	0	0	0	0	35,756	194.00
194.01	07951	TRAFALGAR CLINIC	0	0	0	0	0	194.01
194.02	07952	EDINBURGH	0	0	0	0	0	194.02
194.03	07953	JAIL	0	0	0	0	0	194.03
194.04	07954	ATHLETIC TRAINERS	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	685,255	1,497,796	2,352,532		4,719,342	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.037530	0.004092	0.006427		0.047054	203.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0001 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B-1 | Date/Time Prepared: 5/24/2023 9:39 am

	Cost Center Description	MATERIALS MANAGEMENT (SUPPLY USAGE)	ADMITTING (GROSS CHARGES)	PATIENT ACCOUNTING (GROSS CHARGES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
		4.03	4.04	4.05	5A	5.00	
204.00	Cost to be allocated (per Wkst. B, Part II)	78,960	105,484	234,151		309,910	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.004324	0.000288	0.000640		0.003090	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: 15-0001 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B-1 | Date/Time Prepared: 5/24/2023 9:39 am

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (HOURS PAID)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401	COMMUNICATIONS						4.01
4.02	00402	DATA PROCESSING						4.02
4.03	00403	MATERIALS MANAGEMENT						4.03
4.04	00404	ADMITTING						4.04
4.05	00405	PATIENT ACCOUNTING						4.05
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	180,030					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,404	448,409				8.00
9.00	00900	HOUSEKEEPING	1,867	74,592	175,759			9.00
10.00	01000	DIETARY	3,917	7,389	3,917	21,024		10.00
11.00	01100	CAFETERIA	4,171	0	4,171	0	670,309	11.00
13.00	01300	NURSING ADMINISTRATION	9,867	0	9,867	0	20,089	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,699	0	1,699	0	4,449	14.00
15.00	01500	PHARMACY	2,046	0	2,046	0	22,849	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,879	0	3,879	0	29,048	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	27,577	134,391	27,577	18,924	106,966	30.00
31.00	03100	INTENSIVE CARE UNIT	7,886	34,508	7,886	2,100	34,115	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	625	0	625	0	18,854	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	45,761	60,045	45,761	0	65,119	50.00
53.00	05300	ANESTHESIOLOGY	394	0	394	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	16,532	24,144	16,532	0	61,641	54.00
60.00	06000	LABORATORY	8,049	0	8,049	0	77,201	60.00
65.00	06500	RESPIRATORY THERAPY	374	0	374	0	32,206	65.00
66.00	06600	PHYSICAL THERAPY	6,338	5,942	6,338	0	23,683	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,335	0	1,335	0	6,727	67.00
68.00	06800	SPEECH PATHOLOGY	83	0	83	0	3,546	68.00
69.00	06900	ELECTROCARDIOLOGY	1,080	2,242	1,080	0	12,635	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	182	0	182	0	471	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	ONCOLOGY	6,999	0	6,999	0	15,767	76.00
76.97	07697	CARDIAC REHABILITATION	2,511	0	2,511	0	4,388	76.97
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	11,516	1,502	11,516	0	39,171	90.00
91.00	09100	EMERGENCY	9,934	99,247	9,934	0	63,997	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,305	0	1,305	0	14,583	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)	178,331	444,002	174,060	21,024	657,505	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,297	0	1,297	0	12,804	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	4,407	0	0	0	192.00
192.01	19201	SOUTH CLINIC	0	0	0	0	0	192.01
192.02	19202	WEST CLINIC	0	0	0	0	0	192.02
192.03	19203	DIABETES CENTER	402	0	402	0	0	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	ADULT/CHILD CARE	0	0	0	0	0	193.01
193.02	19302	PHYSICIAN OFFICE BUILDING	0	0	0	0	0	193.02
193.03	19303	OPTIFAST/FOUNDATION	0	0	0	0	0	193.03
194.00	07950	PARTNERSHIP HFC	0	0	0	0	0	194.00
194.01	07951	TRAFALGAR CLINIC	0	0	0	0	0	194.01
194.02	07952	EDINBURGH	0	0	0	0	0	194.02
194.03	07953	JAIL	0	0	0	0	0	194.03
194.04	07954	ATHLETIC TRAINERS	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	5,613,205	415,323	1,208,362	844,812	760,360	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	31.179276	0.926215	6.875107	40.183219	1.134343	203.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0001 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B-1 | Date/Time Prepared: 5/24/2023 9:39 am

	Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (HOURS PAID)	
		7.00	8.00	9.00	10.00	11.00	
204.00	Cost to be allocated (per Wkst. B, Part II)	515,926	63,885	48,708	110,794	65,710	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	2.865778	0.142470	0.277129	5.269882	0.098029	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: 15-0001 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B-1 | Date/Time Prepared: 5/24/2023 9:39 am

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)		
			13.00	14.00	15.00	16.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401	COMMUNICATIONS						4.01
4.02	00402	DATA PROCESSING						4.02
4.03	00403	MATERIALS MANAGEMENT						4.03
4.04	00404	ADMITTING						4.04
4.05	00405	PATIENT ACCOUNTING						4.05
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	289,051					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	100				14.00
15.00	01500	PHARMACY	0	0	100			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	366,025,037		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	125,820	0	0	16,849,537		30.00
31.00	03100	INTENSIVE CARE UNIT	34,115	0	0	4,211,590		31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0		41.00
43.00	04300	NURSERY	0	0	0	661,446		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	65,119	0	0	51,246,954		50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	7,832,927		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	81,082,739		54.00
60.00	06000	LABORATORY	0	0	0	55,897,253		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	8,501,791		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	4,640,126		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,347,108		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	583,289		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	5,827,662		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	160,289		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	100	0	13,647,246		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	10,635,036		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	100	37,789,342		73.00
76.00	03020	ONCOLOGY	0	0	0	1,825,622		76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	822,245		76.97
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0		77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	14,918,205		90.00
91.00	09100	EMERGENCY	63,997	0	0	47,092,950		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	451,680		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)	289,051	100	100	366,025,037		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
192.01	19201	SOUTH CLINIC	0	0	0	0		192.01
192.02	19202	WEST CLINIC	0	0	0	0		192.02
192.03	19203	DIABETES CENTER	0	0	0	0		192.03
193.00	19300	NONPAID WORKERS	0	0	0	0		193.00
193.01	19301	ADULT/CHILD CARE	0	0	0	0		193.01
193.02	19302	PHYSICIAN OFFICE BUILDING	0	0	0	0		193.02
193.03	19303	OPTIFAST/FOUNDATION	0	0	0	0		193.03
194.00	07950	PARTNERSHIP HFC	0	0	0	0		194.00
194.01	07951	TRAFALGAR CLINIC	0	0	0	0		194.01
194.02	07952	EDINBURGH	0	0	0	0		194.02
194.03	07953	JAIL	0	0	0	0		194.03
194.04	07954	ATHLETIC TRAINERS	0	0	0	0		194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,323,099	257,042	2,622,813	1,450,115		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	8.036987	2,570.420000	26,228.130000	0.003962		203.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0001 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B-1 | Date/Time Prepared: 5/24/2023 9:39 am

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)		
			13.00	14.00	15.00	16.00		
204.00		Cost to be allocated (per Wkst. B, Part II)	253,189	73,428	138,752	127,861		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.875932	734.280000	1,387.520000	0.000349		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: 15-0001 | Period: From 01/01/2022 To 12/31/2022 | Worksheet C Part I Date/Time Prepared: 5/24/2023 9:39 am

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		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,971,663		11,971,663	0	11,971,663	30.00
31.00	03100	INTENSIVE CARE UNIT	4,135,595		4,135,595	0	4,135,595	31.00
41.00	04100	SUBPROVIDER - IRF	0		0	0	0	41.00
43.00	04300	NURSERY	400,783		400,783	0	400,783	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,636,560		8,636,560	0	8,636,560	50.00
53.00	05300	ANESTHESIOLOGY	1,579,179		1,579,179	0	1,579,179	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,846,213		6,846,213	0	6,846,213	54.00
60.00	06000	LABORATORY	8,561,126		8,561,126	0	8,561,126	60.00
65.00	06500	RESPIRATORY THERAPY	2,910,270	0	2,910,270	0	2,910,270	65.00
66.00	06600	PHYSICAL THERAPY	1,736,972	0	1,736,972	0	1,736,972	66.00
67.00	06700	OCCUPATIONAL THERAPY	510,401	0	510,401	0	510,401	67.00
68.00	06800	SPEECH PATHOLOGY	232,624	0	232,624	0	232,624	68.00
69.00	06900	ELECTROCARDIOLOGY	1,013,389		1,013,389	0	1,013,389	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	36,576		36,576	0	36,576	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,942,790		2,942,790	0	2,942,790	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	3,871,089		3,871,089	0	3,871,089	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	11,491,440		11,491,440	0	11,491,440	73.00
76.00	03020	ONCOLOGY	1,407,014		1,407,014	10,297	1,417,311	76.00
76.97	07697	CARDIAC REHABILITATION	411,668		411,668	0	411,668	76.97
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0		0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	3,648,762		3,648,762	0	3,648,762	90.00
91.00	09100	EMERGENCY	7,201,628		7,201,628	0	7,201,628	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	4,107,023		4,107,023		4,107,023	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,065,165		1,065,165		1,065,165	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)	84,717,930	0	84,717,930	10,297	84,728,227	200.00
201.00		Less Observation Beds	4,107,023		4,107,023		4,107,023	201.00
202.00		Total (see instructions)	80,610,907	0	80,610,907	10,297	80,621,204	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0001 | Period: From 01/01/2022 To 12/31/2022 | Worksheet C Part I Date/Time Prepared: 5/24/2023 9:39 am

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		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,894,028		11,894,028			30.00
31.00	03100	INTENSIVE CARE UNIT	4,211,590		4,211,590			31.00
41.00	04100	SUBPROVIDER - IRF	0		0			41.00
43.00	04300	NURSERY	661,446		661,446			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,428,696	43,818,258	51,246,954	0.168528	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	1,261,367	6,571,560	7,832,927	0.201608	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,272,974	70,809,765	81,082,739	0.084435	0.000000	54.00
60.00	06000	LABORATORY	12,012,761	43,884,492	55,897,253	0.153158	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	3,255,071	5,246,720	8,501,791	0.342313	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	468,256	4,171,870	4,640,126	0.374337	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	449,947	897,161	1,347,108	0.378886	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	190,917	392,372	583,289	0.398814	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	1,367,364	4,460,298	5,827,662	0.173893	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	46,125	114,164	160,289	0.228188	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,296,038	10,351,208	13,647,246	0.215633	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	2,295,800	8,339,236	10,635,036	0.363994	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,873,346	29,915,996	37,789,342	0.304092	0.000000	73.00
76.00	03020	ONCOLOGY	4,344	1,821,278	1,825,622	0.770704	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	822,245	822,245	0.500663	0.000000	76.97
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0.000000	0.000000	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	30,000	14,888,205	14,918,205	0.244585	0.000000	90.00
91.00	09100	EMERGENCY	5,166,752	41,926,198	47,092,950	0.152924	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	450,000	4,505,509	4,955,509	0.828779	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	451,680	451,680			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)	72,636,822	293,388,215	366,025,037			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	72,636,822	293,388,215	366,025,037			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0001 | Period: From 01/01/2022 To 12/31/2022 | Worksheet C Part I Date/Time Prepared: 5/24/2023 9:39 am

Title XVIII | 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
41.00	04100	SUBPROVIDER - IRF			41.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.168528		50.00
53.00	05300	ANESTHESIOLOGY	0.201608		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.084435		54.00
60.00	06000	LABORATORY	0.153158		60.00
65.00	06500	RESPIRATORY THERAPY	0.342313		65.00
66.00	06600	PHYSICAL THERAPY	0.374337		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.378886		67.00
68.00	06800	SPEECH PATHOLOGY	0.398814		68.00
69.00	06900	ELECTROCARDIOLOGY	0.173893		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.228188		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.215633		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.363994		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.304092		73.00
76.00	03020	ONCOLOGY	0.776344		76.00
76.97	07697	CARDIAC REHABILITATION	0.500663		76.97
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0.000000		77.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.244585		90.00
91.00	09100	EMERGENCY	0.152924		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.828779		92.00
		OTHER REIMBURSABLE COST CENTERS			
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: 15-0001 | Period: From 01/01/2022 To 12/31/2022 | Worksheet C Part I Date/Time Prepared: 5/24/2023 9:39 am

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,971,663		11,971,663	0	11,971,663	30.00
31.00	03100	INTENSIVE CARE UNIT	4,135,595		4,135,595	0	4,135,595	31.00
41.00	04100	SUBPROVIDER - IRF	0		0	0	0	41.00
43.00	04300	NURSERY	400,783		400,783	0	400,783	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,636,560		8,636,560	0	8,636,560	50.00
53.00	05300	ANESTHESIOLOGY	1,579,179		1,579,179	0	1,579,179	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,846,213		6,846,213	0	6,846,213	54.00
60.00	06000	LABORATORY	8,561,126		8,561,126	0	8,561,126	60.00
65.00	06500	RESPIRATORY THERAPY	2,910,270	0	2,910,270	0	2,910,270	65.00
66.00	06600	PHYSICAL THERAPY	1,736,972	0	1,736,972	0	1,736,972	66.00
67.00	06700	OCCUPATIONAL THERAPY	510,401	0	510,401	0	510,401	67.00
68.00	06800	SPEECH PATHOLOGY	232,624	0	232,624	0	232,624	68.00
69.00	06900	ELECTROCARDIOLOGY	1,013,389		1,013,389	0	1,013,389	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	36,576		36,576	0	36,576	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,942,790		2,942,790	0	2,942,790	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	3,871,089		3,871,089	0	3,871,089	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	11,491,440		11,491,440	0	11,491,440	73.00
76.00	03020	ONCOLOGY	1,407,014		1,407,014	10,297	1,417,311	76.00
76.97	07697	CARDIAC REHABILITATION	411,668		411,668	0	411,668	76.97
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0		0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	3,648,762		3,648,762	0	3,648,762	90.00
91.00	09100	EMERGENCY	7,201,628		7,201,628	0	7,201,628	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	4,107,023		4,107,023		4,107,023	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,065,165		1,065,165		1,065,165	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)	84,717,930	0	84,717,930	10,297	84,728,227	200.00
201.00		Less Observation Beds	4,107,023		4,107,023		4,107,023	201.00
202.00		Total (see instructions)	80,610,907	0	80,610,907	10,297	80,621,204	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0001 | Period: From 01/01/2022 To 12/31/2022 | Worksheet C Part I Date/Time Prepared: 5/24/2023 9:39 am

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,894,028		11,894,028			30.00
31.00	03100	INTENSIVE CARE UNIT	4,211,590		4,211,590			31.00
41.00	04100	SUBPROVIDER - IRF	0		0			41.00
43.00	04300	NURSERY	661,446		661,446			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,428,696	43,818,258	51,246,954	0.168528	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	1,261,367	6,571,560	7,832,927	0.201608	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,272,974	70,809,765	81,082,739	0.084435	0.000000	54.00
60.00	06000	LABORATORY	12,012,761	43,884,492	55,897,253	0.153158	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	3,255,071	5,246,720	8,501,791	0.342313	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	468,256	4,171,870	4,640,126	0.374337	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	449,947	897,161	1,347,108	0.378886	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	190,917	392,372	583,289	0.398814	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	1,367,364	4,460,298	5,827,662	0.173893	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	46,125	114,164	160,289	0.228188	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,296,038	10,351,208	13,647,246	0.215633	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	2,295,800	8,339,236	10,635,036	0.363994	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,873,346	29,915,996	37,789,342	0.304092	0.000000	73.00
76.00	03020	ONCOLOGY	4,344	1,821,278	1,825,622	0.770704	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	822,245	822,245	0.500663	0.000000	76.97
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0.000000	0.000000	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	30,000	14,888,205	14,918,205	0.244585	0.000000	90.00
91.00	09100	EMERGENCY	5,166,752	41,926,198	47,092,950	0.152924	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	450,000	4,505,509	4,955,509	0.828779	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	451,680	451,680			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)	72,636,822	293,388,215	366,025,037			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	72,636,822	293,388,215	366,025,037			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0001 | Period: From 01/01/2022 To 12/31/2022 | Worksheet C Part I Date/Time Prepared: 5/24/2023 9:39 am

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
41.00	04100	SUBPROVIDER - IRF			41.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03020	ONCOLOGY	0.000000		76.00
76.97	07697	CARDIAC REHABILITATION	0.000000		76.97
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0.000000		77.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY			101.00
102.00	10200	OPIOID TREATMENT PROGRAM			102.00
		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

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-0001 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part I Date/Time Prepared: 5/24/2023 9:39 am

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,042,790	0	1,042,790	7,847	132.89	30.00
31.00	INTENSIVE CARE UNIT	294,351		294,351	1,544	190.64	31.00
41.00	SUBPROVIDER - IRF	0	0	0	0	0.00	41.00
43.00	NURSERY	13,455		13,455	508	26.49	43.00
200.00	Total (lines 30 through 199)	1,350,596		1,350,596	9,899		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	
		6.00	7.00	
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	1,711	227,375	30.00
31.00	INTENSIVE CARE UNIT	510	97,226	31.00
41.00	SUBPROVIDER - IRF	0	0	41.00
43.00	NURSERY	0	0	43.00
200.00	Total (lines 30 through 199)	2,221	324,601	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-0001 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part II Date/Time Prepared: 5/24/2023 9:39 am

Title XVIII | 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	1,681,843	51,246,954	0.032818	1,461,578	47,966	50.00
53.00	05300	ANESTHESIOLOGY	41,177	7,832,927	0.005257	243,425	1,280	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	935,396	81,082,739	0.011536	3,323,440	38,339	54.00
60.00	06000	LABORATORY	519,466	55,897,253	0.009293	3,565,406	33,133	60.00
65.00	06500	RESPIRATORY THERAPY	97,677	8,501,791	0.011489	678,164	7,791	65.00
66.00	06600	PHYSICAL THERAPY	151,093	4,640,126	0.032562	190,473	6,202	66.00
67.00	06700	OCCUPATIONAL THERAPY	34,477	1,347,108	0.025593	188,634	4,828	67.00
68.00	06800	SPEECH PATHOLOGY	8,638	583,289	0.014809	90,912	1,346	68.00
69.00	06900	ELECTROCARDIOLOGY	97,301	5,827,662	0.016696	975,858	16,293	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	5,722	160,289	0.035698	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	136,641	13,647,246	0.010012	704,378	7,052	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	24,881	10,635,036	0.002340	788,077	1,844	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	212,739	37,789,342	0.005630	2,399,260	13,508	73.00
76.00	03020	ONCOLOGY	184,951	1,825,622	0.101308	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	55,350	822,245	0.067316	0	0	76.97
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0.000000	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	330,711	14,918,205	0.022168	28,216	625	90.00
91.00	09100	EMERGENCY	457,818	47,092,950	0.009722	1,639,081	15,935	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	357,742	4,955,509	0.072191	436,683	31,525	92.00
200.00		Total (lines 50 through 199)	5,333,623	348,806,293		16,713,585	227,667	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0001 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part III Date/Time Prepared: 5/24/2023 9:39 am

Title XVIII | 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
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	7,847	0.00	1,711	30.00
31.00	03100	INTENSIVE CARE UNIT		0	1,544	0.00	510	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0.00	0	41.00
43.00	04300	NURSERY		0	508	0.00	0	43.00
200.00		Total (lines 30 through 199)		0	9,899		2,221	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
41.00	04100	SUBPROVIDER - IRF	0	41.00
43.00	04300	NURSERY	0	43.00
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0001 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part IV Date/Time Prepared: 5/24/2023 9:39 am

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	ONCOLOGY	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0001 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part IV Date/Time Prepared: 5/24/2023 9:39 am

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		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	51,246,954	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	7,832,927	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	81,082,739	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	55,897,253	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	8,501,791	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	4,640,126	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,347,108	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	583,289	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	5,827,662	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	160,289	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	13,647,246	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	10,635,036	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	37,789,342	0.000000	73.00
76.00	03020	ONCOLOGY	0	0	0	1,825,622	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	822,245	0.000000	76.97
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0.000000	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	14,918,205	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	47,092,950	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	4,955,509	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	348,806,293		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0001 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part IV Date/Time Prepared: 5/24/2023 9:39 am

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		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	1,461,578	0	6,585,378	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	243,425	0	664,248	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	3,323,440	0	12,276,454	0	54.00
60.00	06000	LABORATORY	0.000000	3,565,406	0	3,088,817	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	678,164	0	278,635	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	190,473	0	47,386	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	188,634	0	7,810	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	90,912	0	15,242	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	975,858	0	1,645,889	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	704,378	0	1,342,313	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	788,077	0	967,335	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	2,399,260	0	7,805,914	0	73.00
76.00	03020	ONCOLOGY	0.000000	0	0	225,913	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	186,728	0	76.97
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0.000000	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	28,216	0	3,113,472	0	90.00
91.00	09100	EMERGENCY	0.000000	1,639,081	0	4,427,822	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	436,683	0	925,351	0	92.00
200.00		Total (lines 50 through 199)		16,713,585	0	43,604,707	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0001 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part V Date/Time Prepared: 5/24/2023 9:39 am

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		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	0.168528	6,585,378	0	0	1,109,821	50.00
53.00	05300	ANESTHESIOLOGY	0.201608	664,248	0	0	133,918	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.084435	12,276,454	0	0	1,036,562	54.00
60.00	06000	LABORATORY	0.153158	3,088,817	0	0	473,077	60.00
65.00	06500	RESPIRATORY THERAPY	0.342313	278,635	0	0	95,380	65.00
66.00	06600	PHYSICAL THERAPY	0.374337	47,386	0	0	17,738	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.378886	7,810	0	0	2,959	67.00
68.00	06800	SPEECH PATHOLOGY	0.398814	15,242	0	0	6,079	68.00
69.00	06900	ELECTROCARDIOLOGY	0.173893	1,645,889	0	0	286,209	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.228188	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.215633	1,342,313	0	0	289,447	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.363994	967,335	0	0	352,104	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.304092	7,805,914	0	0	2,373,716	73.00
76.00	03020	ONCOLOGY	0.770704	225,913	0	0	174,112	76.00
76.97	07697	CARDIAC REHABILITATION	0.500663	186,728	0	0	93,488	76.97
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0.000000	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.244585	3,113,472	0	0	761,509	90.00
91.00	09100	EMERGENCY	0.152924	4,427,822	0	0	677,120	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.828779	925,351	0	0	766,911	92.00
200.00		Subtotal (see instructions)		43,604,707	0	0	8,650,150	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		43,604,707	0	0	8,650,150	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0001 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part V Date/Time Prepared: 5/24/2023 9:39 am

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		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00	03020	ONCOLOGY	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0		77.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	0		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0001 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-1 | Date/Time Prepared: 5/24/2023 9:39 am

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	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	7,847	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	7,847	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	5,155	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	1,711	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	11,971,663	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	11,971,663	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)	11,971,663	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,525.64	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,610,370	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)	2,610,370	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0001 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-1 | Date/Time Prepared: 5/24/2023 9:39 am

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	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	4,135,595	1,544	2,678.49	510	1,366,030	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	3,490,754	48.00
48.01	Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)	0	48.01
49.00	Total Program inpatient costs (sum of lines 41 through 48.01)(see instructions)	7,467,154	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)	324,601	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	227,667	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	552,268	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	6,914,886	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
55.01	Permanent adjustment amount per discharge	0.00	55.01
55.02	Adjustment amount per discharge (contractor use only)	0.00	55.02
56.00	Target amount (line 54 x sum of lines 55, 55.01, and 55.02)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)	0.00	59.00
60.00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)	0.00	60.00
61.00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	2,692	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,525.64	88.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0001 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-1 | Date/Time Prepared: 5/24/2023 9:39 am

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	Cost Center Description		
		1.00	
89.00	Observation bed cost (line 87 x line 88) (see instructions)	4,107,023	89.00

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	1,042,790	11,971,663	0.087105	4,107,023	357,742	90.00
91.00	Nursing Program cost	0	11,971,663	0.000000	4,107,023	0	91.00
92.00	Allied health cost	0	11,971,663	0.000000	4,107,023	0	92.00
93.00	All other Medical Education	0	11,971,663	0.000000	4,107,023	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0001 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-1 | Date/Time Prepared: 5/24/2023 9:39 am

Title XIX | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	7,847	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	7,847	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	5,155	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	73	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)	508	15.00
16.00	Nursery days (title V or XIX only)	17	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	11,971,663	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	11,971,663	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)	11,971,663	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,525.64	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	111,372	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)	111,372	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0001 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-1 | Date/Time Prepared: 5/24/2023 9:39 am

Title XIX | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	400,783	508	788.94	17	13,412	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	4,135,595	1,544	2,678.49	4	10,714	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)	81,840	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)	217,338	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
55.01	Permanent adjustment amount per discharge	0.00	55.01
55.02	Adjustment amount per discharge (contractor use only)	0.00	55.02
56.00	Target amount (line 54 x sum of lines 55, 55.01, and 55.02)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)	0.00	59.00
60.00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)	0.00	60.00
61.00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	2,692	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,525.64	88.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0001 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-1 | Date/Time Prepared: 5/24/2023 9:39 am

Title XIX | Hospital | Cost

	Cost Center Description		
		1.00	
89.00	Observation bed cost (line 87 x line 88) (see instructions)	4,107,023	89.00

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	1,042,790	11,971,663	0.087105	4,107,023	357,742	90.00
91.00	Nursing Program cost	0	11,971,663	0.000000	4,107,023	0	91.00
92.00	Allied health cost	0	11,971,663	0.000000	4,107,023	0	92.00
93.00	All other Medical Education	0	11,971,663	0.000000	4,107,023	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0001 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-3 | Date/Time Prepared: 5/24/2023 9:39 am

Title XVIII | 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		3,677,019		30.00
31.00	03100	INTENSIVE CARE UNIT		658,230		31.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.168528	1,461,578	246,317	50.00
53.00	05300	ANESTHESIOLOGY	0.201608	243,425	49,076	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.084435	3,323,440	280,615	54.00
60.00	06000	LABORATORY	0.153158	3,565,406	546,070	60.00
65.00	06500	RESPIRATORY THERAPY	0.342313	678,164	232,144	65.00
66.00	06600	PHYSICAL THERAPY	0.374337	190,473	71,301	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.378886	188,634	71,471	67.00
68.00	06800	SPEECH PATHOLOGY	0.398814	90,912	36,257	68.00
69.00	06900	ELECTROCARDIOLOGY	0.173893	975,858	169,695	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.228188	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.215633	704,378	151,887	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.363994	788,077	286,855	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.304092	2,399,260	729,596	73.00
76.00	03020	ONCOLOGY	0.776344	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.500663	0	0	76.97
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0.000000	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.244585	28,216	6,901	90.00
91.00	09100	EMERGENCY	0.152924	1,639,081	250,655	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.828779	436,683	361,914	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		16,713,585	3,490,754	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)		16,713,585		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0001 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-3 | Date/Time Prepared: 5/24/2023 9:39 am

Title XIX | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		321,179		30.00
31.00	03100	INTENSIVE CARE UNIT		6,135		31.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
43.00	04300	NURSERY		0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.168528	165,635	27,914	50.00
53.00	05300	ANESTHESIOLOGY	0.201608	22,447	4,525	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.084435	37,080	3,131	54.00
60.00	06000	LABORATORY	0.153158	82,526	12,640	60.00
65.00	06500	RESPIRATORY THERAPY	0.342313	15,745	5,390	65.00
66.00	06600	PHYSICAL THERAPY	0.374337	1,375	515	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.378886	1,142	433	67.00
68.00	06800	SPEECH PATHOLOGY	0.398814	287	114	68.00
69.00	06900	ELECTROCARDIOLOGY	0.173893	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.228188	99	23	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.215633	20,345	4,387	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.363994	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.304092	56,453	17,167	73.00
76.00	03020	ONCOLOGY	0.770704	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.500663	0	0	76.97
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0.000000	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.244585	0	0	90.00
91.00	09100	EMERGENCY	0.152924	36,629	5,601	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.828779	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		439,763	81,840	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)		439,763		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0001	Period: From 01/01/2022 To 12/31/2022	Worksheet E Part A Date/Time Prepared: 5/24/2023 9:39 am
	Title XVIII	Hospital	PPS

		1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		
1.00	DRG Amounts Other than Outlier Payments	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	4,395,842	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	0	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)	0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)	0	1.04
2.00	Outlier payments for discharges. (see instructions)		2.00
2.01	Outlier reconciliation amount	0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)	0	2.02
2.03	Outlier payments for discharges occurring prior to October 1 (see instructions)	43,042	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)	0	2.04
3.00	Managed Care Simulated Payments	2,273,483	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	50.58	4.00
	Indirect Medical Education Adjustment		
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)	0.00	5.00
5.01	FTE cap adjustment for qualifing hospitals under §131 of the CAA 2021 (see instructions)	0.00	5.01
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)	0.00	6.00
6.26	Rural track program FTE cap limitation adjustment after the cap-building window closed under §127 of the CAA 2021 (see instructions)	0.00	6.26
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.	0.00	7.01
7.02	Adjustment (increase or decrease) to the hospital's rural track program FTE limitation(s) for rural track programs with a rural track for Medicare GME affiliated programs in accordance with 413.75(b) and 87 FR 49075 (August 10, 2022) (see instructions)	0.00	7.02
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.	0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)	0.00	8.02
8.21	The amount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (see instructions)	0.00	8.21
9.00	Sum of lines 5 and 5.01, plus line 6, plus lines 6.26 through 6.49, minus lines 7 and 7.01, plus or minus line 7.02, plus/minus line 8, plus lines 8.01 through 8.27 (see instructions)	0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.	0.00	11.00
12.00	Current year allowable FTE (see instructions)	0.00	12.00
13.00	Total allowable FTE count for the prior year.	0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.	0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.	0.00	15.00
16.00	Adjustment for residents in initial years of the program (see instructions)	0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure	0.00	17.00
18.00	Adjusted rolling average FTE count	0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)	0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.000000	21.00
22.00	IME payment adjustment (see instructions)	0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)	0	22.01
	Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA		
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).	0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)	0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)	0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)	0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)	0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)	0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)	0	28.01
29.00	Total IME payment (sum of lines 22 and 28)	0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	0	29.01
	Disproportionate Share Adjustment		
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	2.30	30.00
31.00	Percentage of Medicaid patient days (see instructions)	21.73	31.00
32.00	Sum of lines 30 and 31	24.03	32.00
33.00	Allowable disproportionate share percentage (see instructions)	9.08	33.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0001	Period: From 01/01/2022 To 12/31/2022	Worksheet E Part A Date/Time Prepared: 5/24/2023 9:39 am
	Title XVIII	Hospital	PPS

			1.00	
34.00	Disproportionate share adjustment (see instructions)		99,786	34.00
		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	Uncompensated Care Payment Adjustment			
35.00	Total uncompensated care amount (see instructions)	0	0	35.00
35.01	Factor 3 (see instructions)	0.000000000	0.000000000	35.01
35.02	Hospital UCP, including supplemental UCP (If line 34 is zero, enter zero on this line) (see instructions)	403,479	368,115	35.02
35.03	Pro rata share of the hospital UCP, including supplemental UCP (see instructions)	301,780	92,785	35.03
36.00	Total UCP adjustment (sum of columns 1 and 2 on line 35.03)	394,565		36.00
	Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)			
40.00	Total Medicare discharges (see instructions)	0		40.00
41.00	Total ESRD Medicare discharges (see instructions)	0		41.00
41.01	Total ESRD Medicare covered and paid discharges (see instructions)	0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days (see instructions)	0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00
47.00	Subtotal (see instructions)	4,933,235		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	0		48.00
			Amount	
			1.00	
49.00	Total payment for inpatient operating costs (see instructions)		4,933,235	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		333,459	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).		0	52.00
53.00	Nursing and Allied Health Managed Care payment		0	53.00
54.00	Special add-on payments for new technologies		135,492	54.00
54.01	Islet isolation add-on payment		0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0	55.00
55.01	Cellular therapy acquisition cost (see instructions)		0	55.01
56.00	Cost of physicians' services in a teaching hospital (see intructions)		0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		0	58.00
59.00	Total (sum of amounts on lines 49 through 58)		5,402,186	59.00
60.00	Primary payer payments		11,796	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		5,390,390	61.00
62.00	Deductibles billed to program beneficiaries		639,084	62.00
63.00	Coinsurance billed to program beneficiaries		3,501	63.00
64.00	Allowable bad debts (see instructions)		63,845	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		41,499	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		18,439	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		4,789,304	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)		0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	70.00
70.50	Rural Community Hospital Demonstration Project (§410A Demonstration) adjustment (see instructions)		0	70.50
70.75	N95 respirator payment adjustment amount (see instructions)		0	70.75
70.87	Demonstration payment adjustment amount before sequestration		0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)		0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)			70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		0	70.91
70.92	Bundled Model 1 discount amount (see instructions)		0	70.92
70.93	HVBP payment adjustment amount (see instructions)		0	70.93
70.94	HRR adjustment amount (see instructions)		-369	70.94
70.95	Recovery of accelerated depreciation		0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0001	Period: From 01/01/2022 To 12/31/2022	Worksheet E Part A Date/Time Prepared: 5/24/2023 9:39 am
	Title XVIII	Hospital	PPS

		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		4,788,935	71.00
71.01	Sequestration adjustment (see instructions)		60,340	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
71.03	Sequestration adjustment-PARHM or CHART pass-throughs			71.03
72.00	Interim payments		4,606,834	72.00
72.01	Interim payments-PARHM or CHART			72.01
73.00	Tentative settlement (for contractor use only)		0	73.00
73.01	Tentative settlement-PARHM or CHART (for contractor use only)			73.01
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		121,761	74.00
74.01	Balance due provider/program-PARHM or CHART (see instructions)			74.01
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		86,770	75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0001	Period: From 01/01/2022 To 12/31/2022	Worksheet E Part B Date/Time Prepared: 5/24/2023 9:39 am
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	8,650,150	2.00
3.00	OPPS payments	6,180,210	3.00
4.00	Outlier payment (see instructions)	32,645	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)	0	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)	0	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)	6,212,855	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	1,009,289	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)	5,203,566	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)	5,203,566	30.00
31.00	Primary payer payments	916	31.00
32.00	Subtotal (line 30 minus line 31)	5,202,650	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)	78,528	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	51,043	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	43,197	36.00
37.00	Subtotal (see instructions)	5,253,693	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)	5,253,693	40.00
40.01	Sequestration adjustment (see instructions)	66,196	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	5,136,731	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)	50,766	43.00
43.01	Balance due provider/program-PARHM (see instructions)		43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0001	Period: From 01/01/2022 To 12/31/2022	Worksheet E Part B Date/Time Prepared: 5/24/2023 9:39 am
	Title XVIII	Hospital	PPS

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-0001 | Period: From 01/01/2022 To 12/31/2022 | Worksheet E-1 Part I | Date/Time Prepared: 5/24/2023 9:39 am

Title XVIII | Hospital | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		4,606,834		5,136,731	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)		4,606,834		5,136,731	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		121,761		50,766	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		4,728,595		5,187,497	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: 15-0001	Period: From 01/01/2022 To 12/31/2022	Worksheet E-1 Part II Date/Time Prepared: 5/24/2023 9:39 am
	Title XVIII	Hospital	PPS

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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0001	Period: From 01/01/2022 To 12/31/2022	Worksheet E-3 Part VII Date/Time Prepared: 5/24/2023 9:39 am
	Title XIX	Hospital	Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	217,338		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant programs only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	217,338	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	217,338	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	327,314		8.00
9.00	Ancillary service charges	439,763	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	767,077	0	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	767,077	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	549,739	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	217,338	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	217,338	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	217,338	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	217,338	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	217,338	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	217,338	0	40.00
41.00	Interim payments	353,322	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	-135,984	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

OUTLIER RECONCILIATION AT TENTATIVE SETTLEMENT	Provider CCN: 15-0001	Period: From 01/01/2022 To 12/31/2022	Worksheet E-5 Date/Time Prepared: 5/24/2023 9:39 am
	Title XVIII		PPS

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

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 15-0001 | Period: From 01/01/2022 To 12/31/2022 | Worksheet G | Date/Time Prepared: 5/24/2023 9:39 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	3,788,331	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	28,868,408	0	0	0	4.00
5.00	Other receivable	3,531,745	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	3,003,345	0	0	0	7.00
8.00	Prepaid expenses	148,808,665	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)	188,000,494	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	4,926,609	0	0	0	12.00
13.00	Land improvements	3,096,219	0	0	0	13.00
14.00	Accumulated depreciation	-1,619,464	0	0	0	14.00
15.00	Buildings	0	0	0	0	15.00
16.00	Accumulated depreciation	-36,634,017	0	0	0	16.00
17.00	Leasehold improvements	105,541,099	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	15,086,526	0	0	0	19.00
20.00	Accumulated depreciation	-12,494,606	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	42,679,286	0	0	0	23.00
24.00	Accumulated depreciation	-31,361,131	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)	89,220,521	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	-13,616,788	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	15,759,615	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	2,142,827	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	279,363,842	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	2,836,794	0	0	0	37.00
38.00	Salaries, wages, and fees payable	2,953,615	0	0	0	38.00
39.00	Payroll taxes payable	153,493	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	45,998,664	0	0	0	43.00
44.00	Other current liabilities	3,928,316	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	55,870,882	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	12,955,448	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	12,955,448	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	68,826,330	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	210,537,512				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)	210,537,512	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	279,363,842	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-0001 | Period: From 01/01/2022 To 12/31/2022 | Worksheet G-1 | Date/Time Prepared: 5/24/2023 9:39 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		210,488,993		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		48,519				2.00
3.00	Total (sum of line 1 and line 2)		210,537,512		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		210,537,512		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)		210,537,512		0		19.00

		Endowment Fund	Plant Fund		
		6.00	7.00	8.00	
1.00	Fund balances at beginning of period	0		0	1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)				2.00
3.00	Total (sum of line 1 and line 2)	0		0	3.00
4.00	Additions (credit adjustments) (specify)		0		4.00
5.00			0		5.00
6.00			0		6.00
7.00			0		7.00
8.00			0		8.00
9.00			0		9.00
10.00	Total additions (sum of line 4-9)	0		0	10.00
11.00	Subtotal (line 3 plus line 10)	0		0	11.00
12.00	Deductions (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: 15-0001 | Period: From 01/01/2022 To 12/31/2022 | Worksheet G-2 Parts I & II | Date/Time Prepared: 5/24/2023 9:39 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	15,196,039		15,196,039	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF	0		0	3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	15,196,039		15,196,039	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	2,328,032		2,328,032	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)	2,328,032		2,328,032	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	17,524,071		17,524,071	17.00
18.00	Ancillary services	54,698,797	294,730,817	349,429,614	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		451,680	451,680	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER OUTPATIENT	0	12,824,505	12,824,505	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	72,222,868	308,007,002	380,229,870	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		115,739,024		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)		115,739,024		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 15-0001	Period: From 01/01/2022 To 12/31/2022	Worksheet G-3 Date/Time Prepared: 5/24/2023 9:39 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	380,229,870	1.00
2.00	Less contractual allowances and discounts on patients' accounts	266,044,983	2.00
3.00	Net patient revenues (line 1 minus line 2)	114,184,887	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	115,739,024	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-1,554,137	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	-34	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	OTHER OPERATING INCOME	595,689	24.00
24.01	NON-OPERATING INCOME	586,172	24.01
24.50	COVID-19 PHE Funding	420,829	24.50
25.00	Total other income (sum of lines 6-24)	1,602,656	25.00
26.00	Total (line 5 plus line 25)	48,519	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)	48,519	29.00

ANALYSIS OF HOSPITAL-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 15-0001 | HHA CCN: 15-7510 | Period: From 01/01/2022 To 12/31/2022 | Worksheet H | Date/Time Prepared: 5/24/2023 9:39 am

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		Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of cols. 1 thru 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures			0		0	0	1.00
2.00	Capital Related - Movable Equipment			0		0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	0	4.00
5.00	Administrative and General	176,422	0	23,889	0	109,676	309,987	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	155,161	0	0	0	0	155,161	6.00
7.00	Physical Therapy	143,155	0	0	0	0	143,155	7.00
8.00	Occupational Therapy	72,737	0	0	0	0	72,737	8.00
9.00	Speech Pathology	0	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	42,242	0	0	0	0	42,242	11.00
12.00	Supplies (see instructions)	0	0	0	0	5,025	5,025	12.00
13.00	Drugs	0	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	1,489	0	0	0	0	1,489	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	591,206	0	23,889	0	114,701	729,796	24.00

		Reclassification	Reclassified Trial Balance (col. 6 + col.7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)			
		7.00	8.00	9.00	10.00			
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0	0	0			1.00
2.00	Capital Related - Movable Equipment	0	0	0	0			2.00
3.00	Plant Operation & Maintenance	0	0	0	0			3.00
4.00	Transportation	0	0	0	0			4.00
5.00	Administrative and General	0	309,987	0	309,987			5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	-5,025	150,136	0	150,136			6.00
7.00	Physical Therapy	0	143,155	0	143,155			7.00
8.00	Occupational Therapy	0	72,737	0	72,737			8.00
9.00	Speech Pathology	0	0	0	0			9.00
10.00	Medical Social Services	0	0	0	0			10.00
11.00	Home Health Aide	0	42,242	0	42,242			11.00
12.00	Supplies (see instructions)	0	5,025	0	5,025			12.00
13.00	Drugs	0	0	0	0			13.00
14.00	DME	0	0	0	0			14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0			15.00
16.00	Respiratory Therapy	0	0	0	0			16.00
17.00	Private Duty Nursing	0	0	0	0			17.00
18.00	Clinic	0	0	0	0			18.00
19.00	Health Promotion Activities	0	0	0	0			19.00
20.00	Day Care Program	0	0	0	0			20.00
21.00	Home Delivered Meals Program	0	0	0	0			21.00
22.00	Homemaker Service	0	0	0	0			22.00
23.00	All Others (specify)	0	1,489	0	1,489			23.00
23.50	Telemedicine	0	0	0	0			23.50
24.00	Total (sum of lines 1-23)	-5,025	724,771	0	724,771			24.00

Column, 6 line 24 should agree with the Worksheet A, column 3, line 101, or subscript as applicable.

COST ALLOCATION - HHA GENERAL SERVICE COST | Provider CCN: 15-0001 | HHA CCN: 15-7510 | Period: From 01/01/2022 To 12/31/2022 | Worksheet H-1 Part I | Date/Time Prepared: 5/24/2023 9:39 am

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		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs: Bldgs & Fixtures	Capital Related Costs: Movable Equipment	Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)	
		0	1.00	2.00	3.00	4.00	4A.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0				0	1.00
2.00	Capital Related - Movable Equipment	0		0			0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0		0	3.00
4.00	Transportation	0	0	0	0	0		4.00
5.00	Administrative and General	309,987	0	0	0	0	309,987	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	150,136	0	0	0	0	150,136	6.00
7.00	Physical Therapy	143,155	0	0	0	0	143,155	7.00
8.00	Occupational Therapy	72,737	0	0	0	0	72,737	8.00
9.00	Speech Pathology	0	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	42,242	0	0	0	0	42,242	11.00
12.00	Supplies (see instructions)	5,025	0	0	0	0	5,025	12.00
13.00	Drugs	0	0	0	0		0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	1,489	0	0	0	0	1,489	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	724,771	0	0	0	0	724,771	24.00

		Administrative & General	Total (cols. 4A + 5)	
		5.00	6.00	
	GENERAL SERVICE COST CENTERS			
1.00	Capital Related - Bldg. & Fixtures			1.00
2.00	Capital Related - Movable Equipment			2.00
3.00	Plant Operation & Maintenance			3.00
4.00	Transportation			4.00
5.00	Administrative and General	309,987		5.00
	HHA REIMBURSABLE SERVICES			
6.00	Skilled Nursing Care	112,204	262,340	6.00
7.00	Physical Therapy	106,986	250,141	7.00
8.00	Occupational Therapy	54,360	127,097	8.00
9.00	Speech Pathology	0	0	9.00
10.00	Medical Social Services	0	0	10.00
11.00	Home Health Aide	31,569	73,811	11.00
12.00	Supplies (see instructions)	3,755	8,780	12.00
13.00	Drugs	0	0	13.00
14.00	DME	0	0	14.00
	HHA NONREIMBURSABLE SERVICES			
15.00	Home Dialysis Aide Services	0	0	15.00
16.00	Respiratory Therapy	0	0	16.00
17.00	Private Duty Nursing	0	0	17.00
18.00	Clinic	0	0	18.00
19.00	Health Promotion Activities	0	0	19.00
20.00	Day Care Program	0	0	20.00
21.00	Home Delivered Meals Program	0	0	21.00
22.00	Homemaker Service	0	0	22.00
23.00	All Others (specify)	1,113	2,602	23.00
23.50	Telemedicine	0	0	23.50
24.00	Total (sum of lines 1-23)		724,771	24.00

COST ALLOCATION - HHA STATISTICAL BASIS | Provider CCN: 15-0001 | HHA CCN: 15-7510 | Period: From 01/01/2022 To 12/31/2022 | Worksheet H-1 Part II Date/Time Prepared: 5/24/2023 9:39 am

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		Capital Related Costs						
		Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)	Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
		1.00	2.00	3.00	4.00	5A.00	5.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0				0		1.00
2.00	Capital Related - Movable Equipment		0			0		2.00
3.00	Plant Operation & Maintenance	0	0	0		0		3.00
4.00	Transportation (see instructions)	0	0	0	0			4.00
5.00	Administrative and General	0	0	0	0	-309,987	414,784	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	150,136	6.00
7.00	Physical Therapy	0	0	0	0	0	143,155	7.00
8.00	Occupational Therapy	0	0	0	0	0	72,737	8.00
9.00	Speech Pathology	0	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	0	0	0	0	0	42,242	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	5,025	12.00
13.00	Drugs	0	0	0		0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	1,489	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	0	0	0	0	-309,987	414,784	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		309,987	25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.747346	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 15-0001 | HHA CCN: 15-7510 | Period: From 01/01/2022 To 12/31/2022 | Worksheet H-2 Part I | Date/Time Prepared: 5/24/2023 9:39 am

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	Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS NEW BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	COMMUNICATIONS	DATA PROCESSING	
		0	1.00	2.00	4.00	4.01	4.02	
1.00	Administrative and General	0	15,814	91	135,951	6,450	64,223	1.00
2.00	Skilled Nursing Care	262,340	0	0	0	0	0	2.00
3.00	Physical Therapy	250,141	0	0	0	0	0	3.00
4.00	Occupational Therapy	127,097	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	73,811	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	8,780	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	2,602	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	724,771	15,814	91	135,951	6,450	64,223	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

	Cost Center Description	MATERIALS MANAGEMENT	ADMITTING	PATIENT ACCOUNTING	Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	
		4.03	4.04	4.05	4A.05	5.00	7.00	
1.00	Administrative and General	309	1,848	2,903	227,589	10,709	40,689	1.00
2.00	Skilled Nursing Care	0	0	0	262,340	12,345	0	2.00
3.00	Physical Therapy	0	0	0	250,141	11,770	0	3.00
4.00	Occupational Therapy	0	0	0	127,097	5,980	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	73,811	3,473	0	7.00
8.00	Supplies (see instructions)	0	0	0	8,780	413	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	2,602	122	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	309	1,848	2,903	952,360	44,812	40,689	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.				0.000000			21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 15-0001 | HHA CCN: 15-7510 | Period: From 01/01/2022 To 12/31/2022 | Worksheet H-2 Part I | Date/Time Prepared: 5/24/2023 9:39 am

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	Cost Center Description	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
		8.00	9.00	10.00	11.00	13.00	14.00	
1.00	Administrative and General	0	8,972	0	16,542	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	0	8,972	0	16,542	0	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

	Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	Allocated HHA A&G (see Part II)	
		15.00	16.00	24.00	25.00	26.00	27.00	
1.00	Administrative and General	0	1,790	306,291	0	306,291		1.00
2.00	Skilled Nursing Care	0	0	274,685	0	274,685	110,868	2.00
3.00	Physical Therapy	0	0	261,911	0	261,911	105,710	3.00
4.00	Occupational Therapy	0	0	133,077	0	133,077	53,711	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	77,284	0	77,284	31,193	7.00
8.00	Supplies (see instructions)	0	0	9,193	0	9,193	3,710	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	2,724	0	2,724	1,099	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	0	1,790	1,065,165	0	1,065,165	306,291	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.						0.403612	21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 15-0001 | HHA CCN: 15-7510 | Period: From 01/01/2022 To 12/31/2022 | Worksheet H-2 Part I | Date/Time Prepared: 5/24/2023 9:39 am

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	Cost Center Description	Total HHA Costs				
		28.00				
1.00	Administrative and General					1.00
2.00	Skilled Nursing Care	385,553				2.00
3.00	Physical Therapy	367,621				3.00
4.00	Occupational Therapy	186,788				4.00
5.00	Speech Pathology	0				5.00
6.00	Medical Social Services	0				6.00
7.00	Home Health Aide	108,477				7.00
8.00	Supplies (see instructions)	12,903				8.00
9.00	Drugs	0				9.00
10.00	DME	0				10.00
11.00	Home Dialysis Aide Services	0				11.00
12.00	Respiratory Therapy	0				12.00
13.00	Private Duty Nursing	0				13.00
14.00	Clinic	0				14.00
15.00	Health Promotion Activities	0				15.00
16.00	Day Care Program	0				16.00
17.00	Home Delivered Meals Program	0				17.00
18.00	Homemaker Service	0				18.00
19.00	All Others (specify)	3,823				19.00
19.50	Telemedicine	0				19.50
20.00	Total (sum of lines 1-19) (2)	1,065,165				20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.					21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 15-0001 | HHA CCN: 15-7510 | Period: From 01/01/2022 To 12/31/2022 | Worksheet H-2 Part II | Date/Time Prepared: 5/24/2023 9:39 am

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	Cost Center Description	CAPITAL RELATED COSTS NEW BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	COMMUNICATIONS (# NON PT PHONES)	DATA PROCESSING (WORK ORDERS)	MATERIALS MANAGEMENT (SUPPLY USAGE)	
		1.00	2.00	4.00	4.01	4.02	4.03	
1.00	Administrative and General	1,305	56	591,206	23	35	8,237	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	1,305	56	591,206	23	35	8,237	20.00
21.00	Total cost to be allocated	15,814	91	135,951	6,450	64,223	309	21.00
22.00	Unit cost multiplier	12.118008	1.625000	0.229955	280.434783	1,834.942857	0.037514	22.00

	Cost Center Description	ADMITTING (GROSS CHARGES)	PATIENT ACCOUNTING (GROSS CHARGES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	
		4.04	4.05	5A	5.00	7.00	8.00	
1.00	Administrative and General	451,680	451,680	0	227,589	1,305	0	1.00
2.00	Skilled Nursing Care	0	0	0	262,340	0	0	2.00
3.00	Physical Therapy	0	0	0	250,141	0	0	3.00
4.00	Occupational Therapy	0	0	0	127,097	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	73,811	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	8,780	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	2,602	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	451,680	451,680		952,360	1,305	0	20.00
21.00	Total cost to be allocated	1,848	2,903		44,812	40,689	0	21.00
22.00	Unit cost multiplier	0.004091	0.006427		0.047054	31.179310	0.000000	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 15-0001 HHA CCN: 15-7510

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

Worksheet H-2 Part II Date/Time Prepared: 5/24/2023 9:39 am

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	Cost Center Description	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (HOURS PAID)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
		9.00	10.00	11.00	13.00	14.00	15.00	
1.00	Administrative and General	1,305	0	14,583	0	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	1,305	0	14,583	0	0	0	20.00
21.00	Total cost to be allocated	8,972	0	16,542	0	0	0	21.00
22.00	Unit cost multiplier	6.875096	0.000000	1.134334	0.000000	0.000000	0.000000	22.00

	Cost Center Description	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
		16.00	
1.00	Administrative and General	451,680	1.00
2.00	Skilled Nursing Care	0	2.00
3.00	Physical Therapy	0	3.00
4.00	Occupational Therapy	0	4.00
5.00	Speech Pathology	0	5.00
6.00	Medical Social Services	0	6.00
7.00	Home Health Aide	0	7.00
8.00	Supplies (see instructions)	0	8.00
9.00	Drugs	0	9.00
10.00	DME	0	10.00
11.00	Home Dialysis Aide Services	0	11.00
12.00	Respiratory Therapy	0	12.00
13.00	Private Duty Nursing	0	13.00
14.00	Clinic	0	14.00
15.00	Health Promotion Activities	0	15.00
16.00	Day Care Program	0	16.00
17.00	Home Delivered Meals Program	0	17.00
18.00	Homemaker Service	0	18.00
19.00	All Others (specify)	0	19.00
19.50	Telemedicine	0	19.50
20.00	Total (sum of lines 1-19)	451,680	20.00
21.00	Total cost to be allocated	1,790	21.00
22.00	Unit cost multiplier	0.003963	22.00

APPORTIONMENT OF PATIENT SERVICE COSTS | Provider CCN: 15-0001 | HHA CCN: 15-7510 | Period: From 01/01/2022 To 12/31/2022 | Worksheet H-3 Part I | Date/Time Prepared: 5/24/2023 9:39 am

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	Cost Center Description	From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	2.00	385,553		385,553	956	403.30	1.00
2.00	Physical Therapy	3.00	367,621	0	367,621	1,146	320.79	2.00
3.00	Occupational Therapy	4.00	186,788	0	186,788	762	245.13	3.00
4.00	Speech Pathology	5.00	0	0	0	0	0.00	4.00
5.00	Medical Social Services	6.00	0		0	0	0.00	5.00
6.00	Home Health Aide	7.00	108,477		108,477	36	3,013.25	6.00
7.00	Total (sum of lines 1-6)		1,048,439	0	1,048,439	2,900		7.00

	Cost Center Description	Cost Limits	CBSA No. (1)	Program Visits: Part A	Program Visits: Part B Not Subject to Deductibles & Coinsurance	Program Visits: Part B Subject to Deductibles		
		0	1.00	2.00	3.00	4.00	5.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care		18020	0	291			8.00
9.00	Physical Therapy		18020	0	349			9.00
10.00	Occupational Therapy		18020	0	232			10.00
11.00	Speech Pathology		18020	0	0			11.00
12.00	Medical Social Services		18020	0	0			12.00
13.00	Home Health Aide		18020	0	11			13.00
14.00	Total (sum of lines 8-13)			0	883			14.00

	Cost Center Description	From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Records)	Ratio (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	8.00	12,903	0	12,903	0	0.000000	15.00
16.00	Cost of Drugs	9.00	0	0	0	0	0.000000	16.00

	Cost Center Description	Program Visits: Part A	Program Visits: Part B Not Subject to Deductibles & Coinsurance	Program Visits: Part B Subject to Deductibles & Coinsurance	Cost of Services: Part A	Cost of Services: Part B Not Subject to Deductibles & Coinsurance	Cost of Services: Part B Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	0	291		0	117,360		1.00
2.00	Physical Therapy	0	349		0	111,956		2.00
3.00	Occupational Therapy	0	232		0	56,870		3.00
4.00	Speech Pathology	0	0		0	0		4.00
5.00	Medical Social Services	0	0		0	0		5.00
6.00	Home Health Aide	0	11		0	33,146		6.00
7.00	Total (sum of lines 1-6)	0	883		0	319,332		7.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 15-0001 HHA CCN: 15-7510 | Period: From 01/01/2022 To 12/31/2022 | Worksheet H-3 Part I Date/Time Prepared: 5/24/2023 9:39 am

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	Cost Center Description							
		6.00	7.00	8.00	9.00	10.00	11.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care							8.00
9.00	Physical Therapy							9.00
10.00	Occupational Therapy							10.00
11.00	Speech Pathology							11.00
12.00	Medical Social Services							12.00
13.00	Home Health Aide							13.00
14.00	Total (sum of lines 8-13)							14.00

	Cost Center Description	Program Covered Charges			Cost of Services			
			Part B			Part B		
		Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	0	0	0	0	0	0	15.00
16.00	Cost of Drugs		0	0		0	0	16.00

	Cost Center Description	Total Program Cost (sum of cols. 9-10)						
		12.00						
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	117,360						1.00
2.00	Physical Therapy	111,956						2.00
3.00	Occupational Therapy	56,870						3.00
4.00	Speech Pathology	0						4.00
5.00	Medical Social Services	0						5.00
6.00	Home Health Aide	33,146						6.00
7.00	Total (sum of lines 1-6)	319,332						7.00

	Cost Center Description							
		12.00						
	Limitation Cost Computation							
8.00	Skilled Nursing Care							8.00
9.00	Physical Therapy							9.00
10.00	Occupational Therapy							10.00
11.00	Speech Pathology							11.00
12.00	Medical Social Services							12.00
13.00	Home Health Aide							13.00
14.00	Total (sum of lines 8-13)							14.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 15-0001
HHA CCN: 15-7510

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

Worksheet H-3 Part II
Date/Time Prepared: 5/24/2023 9:39 am

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	Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated		
		0	1.00	2.00	3.00	4.00		
	PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS							
1.00	Physical Therapy	66.00	0.374337	0	0	col. 2, line 2.00		1.00
2.00	Occupational Therapy	67.00	0.378886	0	0	col. 2, line 3.00		2.00
3.00	Speech Pathology	68.00	0.398814	0	0	col. 2, line 4.00		3.00
4.00	Cost of Medical Supplies	71.00	0.215633	0	0	col. 2, line 15.00		4.00
5.00	Cost of Drugs	73.00	0.304092	0	0	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

Provider CCN: 15-0001 | HHA CCN: 15-7510 | Period: From 01/01/2022 To 12/31/2022 | Worksheet H-4 Part I-II | Date/Time Prepared: 5/24/2023 9:39 am

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		Part A	Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles & Coinsurance	
		1.00	2.00	3.00	
	PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES				
	Reasonable Cost of Part A & Part B Services				
1.00	Reasonable cost of services (see instructions)	0	0	0	1.00
2.00	Total charges	0	0	0	2.00
	Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0	3.00
4.00	Amount 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(b)	0	0	0	4.00
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000	5.00
6.00	Total customary charges (see instructions)	0	0	0	6.00
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	0	0	7.00
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0	8.00
9.00	Primary payer amounts	0	0	0	9.00

		Part A Services	Part B Services	
		1.00	2.00	
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT			
10.00	Total reasonable cost (see instructions)	0	0	10.00
11.00	Total PPS Reimbursement - Full Episodes without Outliers	0	235,701	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers	0	0	12.00
13.00	Total PPS Reimbursement - LUPA Episodes	0	2,820	13.00
14.00	Total PPS Reimbursement - PEP Episodes	0	0	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	0	0	15.00
16.00	Total PPS Outlier Reimbursement - PEP Episodes	0	0	16.00
17.00	Total Other Payments	0	0	17.00
18.00	DME Payments	0	0	18.00
19.00	Oxygen Payments	0	0	19.00
20.00	Prosthetic and Orthotic Payments	0	0	20.00
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	21.00
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)	0	238,521	22.00
23.00	Excess reasonable cost (from line 8)	0	0	23.00
24.00	Subtotal (line 22 minus line 23)	0	238,521	24.00
25.00	Coinsurance billed to program patients (from your records)		0	25.00
26.00	Net cost (line 24 minus line 25)	0	238,521	26.00
27.00	Allowable bad debts (from your records)		0	27.00
27.01	Adjusted reimbursable bad debts (see instructions)		0	27.01
28.00	Allowable bad debts for dual eligible (see instructions)		0	28.00
29.00	Total costs - current cost reporting period (see instructions)	0	238,521	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	30.50
30.99	Demonstration payment adjustment amount before sequestration	0	0	30.99
31.00	Subtotal (see instructions)	0	238,521	31.00
31.01	Sequestration adjustment (see instructions)	0	3,675	31.01
31.02	Demonstration payment adjustment amount after sequestration	0	0	31.02
31.75	Sequestration adjustment for non-claims based amounts (see instructions)	0	0	31.75
32.00	Interim payments (see instructions)	0	234,846	32.00
33.00	Tentative settlement (for contractor use only)	0	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 31.02, 31.75, 32, and 33)	0	0	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	35.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED HHAs FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

Provider CCN: 15-0001 | HHA CCN: 15-7510 | Period: From 01/01/2022 To 12/31/2022 | Worksheet H-5 | Date/Time Prepared: 5/24/2023 9:39 am

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		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		0		234,846	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			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			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. H-4, Part II, column as appropriate, line 32)		0		234,846	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		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50			0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		0		234,846	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 15-0001	Period: From 01/01/2022 To 12/31/2022	Worksheet L Parts I-III Date/Time Prepared: 5/24/2023 9:39 am
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	325,890	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	7,569	2.00
2.01	Model 4 BPCI Capital DRG outlier payments	0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)	19.20	3.00
4.00	Number of interns & residents (see instructions)	0.00	4.00
5.00	Indirect medical education percentage (see instructions)	0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)	0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	0.00	8.00
9.00	Sum of lines 7 and 8	0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)	0.00	10.00
11.00	Disproportionate share adjustment (see instructions)	0	11.00
12.00	Total prospective capital payments (see instructions)	333,459	12.00
		1.00	
	PART II - PAYMENT UNDER REASONABLE COST		
1.00	Program inpatient routine capital cost (see instructions)	0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)	0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)	0	3.00
4.00	Capital cost payment factor (see instructions)	0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)	0	5.00
		1.00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS		
1.00	Program inpatient capital costs (see instructions)	0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)	0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)	0	3.00
4.00	Applicable exception percentage (see instructions)	0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)	0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)	0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)	0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)	0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)	0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)	0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)	0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)	0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)	0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)	0	14.00
15.00	Current year allowable operating and capital payment (see instructions)	0	15.00
16.00	Current year operating and capital costs (see instructions)	0	16.00
17.00	Current year exception offset amount (see instructions)	0	17.00