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: 15-0006	Period: From 01/01/2022 To 12/31/2022	Worksheet S Parts I-III Date/Time Prepared: 5/31/2023 1:02 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 5/31/2023 Time: 1:02 pm
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 LAPORTE HOSPITAL (15-0006) 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				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				2
3	Signatory Title				3
4	Date				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	66,359	6,490	0	0	1.00
2.00	SUBPROVIDER - IPF	0	0	0		0	2.00
3.00	SUBPROVIDER - IRF	0	0	0		0	3.00
5.00	SWING BED - SNF	0	-49,862	0		0	5.00
6.00	SWING BED - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7.00
200.00	TOTAL	0	16,497	6,490	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0006 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-2 Part I | Date/Time Prepared: 5/31/2023 1:02 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: STATE & MADISON STREETS	PO Box: 250			1.00
2.00	City: LAPORTE	State: IN	Zip Code: 46350-	County: LA PORTE	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	LAPORTE HOSPITAL	150006	33140	1	07/01/1966	N	P	P	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	LAPORTE HOSPITAL COMPANY LLC	15U006	33140		03/01/2020	N	P	P	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2022	12/31/2022	20.00
21.00	Type of Control (see instructions)	4		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: 15-0006 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-2 Part I | Date/Time Prepared: 5/31/2023 1:02 pm

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	781	114	20	2	4,388	213	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)	Y	N	40.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0006	Period: From 01/01/2022 To 12/31/2022	Worksheet S-2 Part I Date/Time Prepared: 5/31/2023 1:02 pm

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0006 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-2 Part I Date/Time Prepared: 5/31/2023 1:02 pm

				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)	N		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: 15-0006 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-2 Part I Date/Time Prepared: 5/31/2023 1:02 pm

			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.	N	Y		90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	Y		91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		Y		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: 15-0006 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-2 Part I Date/Time Prepared: 5/31/2023 1:02 pm

		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)			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)			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

		V	XIX	
		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.	Y			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0006 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-2 Part I | Date/Time Prepared: 5/31/2023 1:02 pm

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	78,903	97,099	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)	Y	HB1848	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: COMMUNITY HEALTH SYSTEMS	Contractor's Name: WPS	Contractor's Number: 10101	141.00
142.00	Street: 4000 MERIDIAN BLVD	PO Box:		142.00
143.00	City: FRANKLIN	State: TN	Zip Code: 37067	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.	Y		145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0006 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-2 Part I Date/Time Prepared: 5/31/2023 1:02 pm

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

							1.00	
	Multicampus							
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.						N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00	166.00

				1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act				
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.			Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)				168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)			N	168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)			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: 15-0006 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-2 Part II | Date/Time Prepared: 5/31/2023 1:02 pm

			Y/N	Date	
			1.00	2.00	
	PART II - HOSPITAL AND HOSPITAL HEATHCARE COMPLEX REIMBURSEMENT QUESTIONNAIRE				
	General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
	COMPLETED BY ALL HOSPITALS				
	Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)		N		1.00
		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y			3.00
		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		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.			Y	15.00
		Part A		Part B	
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	N		N	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	04/24/2023	Y	04/24/2023 17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N	19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-0006 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-2 Part II Date/Time Prepared: 5/31/2023 1:02 pm

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

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

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?	Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	Y		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	Y	12/31/2021	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	N		40.00

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	TIM	WORTH	41.00
42.00	Enter the employer/company name of the cost report preparer.	COMMUNITY HEALTH SYSTEMS		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	615-380-5041	TIMOTHY_WORTH@CHS.NET	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-0006	Period: From 01/01/2022 To 12/31/2022	Worksheet S-2 Part II Date/Time Prepared: 5/31/2023 1:02 pm

		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	REVENUE 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: 15-0006 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-3 Part I | Date/Time Prepared: 5/31/2023 1:02 pm

	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	60	21,900	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)		60	21,900	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)		74	27,010	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF	40.00	0	0		0	16.00
17.00	SUBPROVIDER - IRF	41.00	0	0		0	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	44.00	0	0		0	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		74				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: 15-0006 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-3 Part I | Date/Time Prepared: 5/31/2023 1:02 pm

	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)	5,740	687	16,288			1.00
2.00	HMO and other (see instructions)	5,306	3,618				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	92	0	124			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)	5,832	687	16,412			7.00
8.00	INTENSIVE CARE UNIT	1,075	39	3,121			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		961	1,305			13.00
14.00	Total (see instructions)	6,907	1,687	20,838	0.00	574.22	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	0	0	0	0.00	0.00	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	0	0	0	0.00	0.00	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			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	574.22	27.00
28.00	Observation Bed Days		0	1,480			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			214			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	213	299			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: 15-0006 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-3 Part I | Date/Time Prepared: 5/31/2023 1:02 pm

	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	1,494	1,094	4,784	1.00
2.00	HMO and other (see instructions)			954	0		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	1,494	1,094	4,784	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF	0.00	0	0	0	0	16.00
17.00	SUBPROVIDER - IRF	0.00	0	0	0	0	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	0.00					19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care						34.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0006 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-3 Part II | Date/Time Prepared: 5/31/2023 1:02 pm

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	44,190,079	0	44,190,079	1,194,372.00	37.00	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		216,000	0	216,000	744.00	290.32	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		0	0	0	0.00	0.00	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)		199,076	0	199,076	6,062.00	32.84	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		6,772,167	0	6,772,167	69,961.00	96.80	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		183,045	0	183,045	725.00	252.48	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		4,875,761	0	4,875,761	126,744.00	38.47	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)		11,199,866	0	11,199,866			17.00
18.00	Wage-related costs (other) (see instructions)							18.00
19.00	Excluded areas		55,690	0	55,690			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		12,052	0	12,052			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		0	0	0			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)		1,205,392	0	1,205,392			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: 15-0006 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-3 Part II Date/Time Prepared: 5/31/2023 1:02 pm

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.53	Home office: Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	270,025	0	270,025	8,705.00	31.02	26.00
27.00	Administrative & General	5.00	7,557,679	-182,412	7,375,267	226,407.00	32.58	27.00
28.00	Administrative & General under contract (see inst.)		255,572	0	255,572	1,594.00	160.33	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	1,058,901	0	1,058,901	40,760.00	25.98	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	0	0	0	0.00	0.00	32.00
33.00	Housekeeping under contract (see instructions)		1,137,695	0	1,137,695	53,831.00	21.13	33.00
34.00	Dietary	10.00	0	0	0	0.00	0.00	34.00
35.00	Dietary under contract (see instructions)		1,647,818	0	1,647,818	70,701.00	23.31	35.00
36.00	Cafeteria	11.00	0	0	0	0.00	0.00	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	2,438,761	182,412	2,621,173	57,263.00	45.77	38.00
39.00	Central Services and Supply	14.00	606,762	0	606,762	25,213.00	24.07	39.00
40.00	Pharmacy	15.00	1,545,300	0	1,545,300	30,885.00	50.03	40.00
41.00	Medical Records & Medical Records Library	16.00	531,033	0	531,033	19,698.00	26.96	41.00
42.00	Social Service	17.00	456,842	0	456,842	13,798.00	33.11	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0006 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-3 Part III Date/Time Prepared: 5/31/2023 1:02 pm

		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)		47,231,164	0	47,231,164	1,320,498.00	35.77	1.00
2.00	Excluded area salaries (see instructions)		199,076	0	199,076	6,062.00	32.84	2.00
3.00	Subtotal salaries (line 1 minus line 2)		47,032,088	0	47,032,088	1,314,436.00	35.78	3.00
4.00	Subtotal other wages & related costs (see inst.)		11,830,973	0	11,830,973	197,430.00	59.92	4.00
5.00	Subtotal wage-related costs (see inst.)		12,417,310	0	12,417,310	0.00	26.40	5.00
6.00	Total (sum of lines 3 thru 5)		71,280,371	0	71,280,371	1,511,866.00	47.15	6.00
7.00	Total overhead cost (see instructions)		17,506,388	0	17,506,388	548,855.00	31.90	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 15-0006 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-3 Part IV Date/Time Prepared: 5/31/2023 1:02 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	912,068	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)	6,556,617	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	92,697	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	35,653	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	-135	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	90,909	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	280,029	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	2,588,015	17.00
18.00	Medicare Taxes - Employers Portion Only	605,262	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	106,494	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	0	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	11,267,609	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: 15-0006 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-3 Part V | Date/Time Prepared: 5/31/2023 1:02 pm

	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	6,772,167	11,267,609	1.00
2.00	Hospital	6,772,167	11,267,609	2.00
3.00	SUBPROVIDER - IPF	0	0	3.00
4.00	SUBPROVIDER - IRF	0	0	4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	SKILLED NURSING FACILITY	0	0	8.00
9.00	NURSING FACILITY			9.00
10.00	OTHER LONG TERM CARE I			10.00
11.00	Hospital-Based HHA			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	0	0	17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-0006 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-10 | Date/Time Prepared: 5/31/2023 1:02 pm

		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)	0.179112	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	21,136,675	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	104,943,263	6.00
7.00	Medicaid cost (line 1 times line 6)	18,796,598	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)	0	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)	0	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)	7,898,183	0	7,898,183	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	1,414,659	0	1,414,659	21.00
22.00	Payments received from patients for amounts previously written off as charity care	2,454	0	2,454	22.00
23.00	Cost of charity care (line 21 minus line 22)	1,412,205	0	1,412,205	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)	6,158,488	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	225,271	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	346,572	27.01
28.00	Non-Medicare bad debt expense (see instructions)	5,811,916	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	1,162,285	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	2,574,490	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	2,574,490	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0006 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A | Date/Time Prepared: 5/31/2023 1:02 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		-553,256	-553,256	2,969,438	2,416,182	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		11,215,116	11,215,116	376,412	11,591,528	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	270,025	154,394	424,419	8,119,377	8,543,796	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	7,557,679	38,954,767	46,512,446	-12,608,615	33,903,831	5.00
7.00	00700	OPERATION OF PLANT	1,058,901	3,400,908	4,459,809	4,637,075	9,096,884	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	511,464	511,464	0	511,464	8.00
9.00	00900	HOUSEKEEPING	0	1,888,410	1,888,410	-17,971	1,870,439	9.00
10.00	01000	DIETARY	0	3,124,261	3,124,261	-1,969,014	1,155,247	10.00
11.00	01100	CAFETERIA	0	0	0	1,888,817	1,888,817	11.00
13.00	01300	NURSING ADMINISTRATION	2,438,761	566,873	3,005,634	145,761	3,151,395	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	606,762	6,949,116	7,555,878	-5,901,194	1,654,684	14.00
15.00	01500	PHARMACY	1,545,300	12,643,080	14,188,380	-12,301,410	1,886,970	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	531,033	730,825	1,261,858	-1,925	1,259,933	16.00
17.00	01700	SOCIAL SERVICE	456,842	301,704	758,546	-5,404	753,142	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,130,124	4,892,266	11,022,390	742,567	11,764,957	30.00
31.00	03100	INTENSIVE CARE UNIT	2,498,668	1,893,877	4,392,545	-38,522	4,354,023	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	0	5,604	5,604	442,034	447,638	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,302,595	5,654,025	7,956,620	-1,488,674	6,467,946	50.00
51.00	05100	RECOVERY ROOM	1,446,453	380,876	1,827,329	-3,192	1,824,137	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,767,876	463,639	2,231,515	-1,239,612	991,903	52.00
53.00	05300	ANESTHESIOLOGY	49,455	1,895,481	1,944,936	-18,165	1,926,771	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,120,537	1,522,340	3,642,877	-798,419	2,844,458	54.00
54.01	05401	ULTRASOUND	382,120	67,783	449,903	-22,475	427,428	54.01
56.00	05600	RADIOISOTOPE	341,616	314,828	656,444	-57,540	598,904	56.00
57.00	05700	CT SCAN	621,560	361,214	982,774	-225,798	756,976	57.00
58.00	05800	MRI	180,950	358,064	539,014	-144,122	394,892	58.00
60.00	06000	LABORATORY	2,399,908	3,490,679	5,890,587	-805,984	5,084,603	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	579,259	579,259	62.00
65.00	06500	RESPIRATORY THERAPY	1,031,929	290,371	1,322,300	-63,542	1,258,758	65.00
66.00	06600	PHYSICAL THERAPY	1,719,528	286,764	2,006,292	-70,946	1,935,346	66.00
67.00	06700	OCCUPATIONAL THERAPY	608,842	77,026	685,868	-1,406	684,462	67.00
68.00	06800	SPEECH PATHOLOGY	544,410	151,413	695,823	-10,491	685,332	68.00
69.00	06900	ELECTROCARDIOLOGY	2,850,595	1,927,409	4,778,004	-711,775	4,066,229	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	1,017,378	1,017,378	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	4,778,359	4,778,359	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	11,919,865	11,919,865	73.00
74.00	07400	RENAL DIALYSIS	62,116	460,579	522,695	-2,400	520,295	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	284,408	78,944	363,352	-17,522	345,830	76.01
76.02	03020	ACUPUNCTURE	0	0	0	0	0	76.02
76.03	03040	WOUND CARE	6,124	871,276	877,400	-6,651	870,749	76.03
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	4,351,825	4,351,825	0	4,351,825	90.00
91.00	09100	EMERGENCY	2,175,886	2,129,427	4,305,313	-22,429	4,282,884	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	43,991,003	111,813,372	155,804,375	-938,856	154,865,519	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	118,975	-798,414	-679,439	940,392	260,953	192.00
194.00	07950	OTHER NONREIMBURSABLE COSTS	80,101	139,766	219,867	-1,536	218,331	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
200.00		TOTAL (SUM OF LINES 118 through 199)	44,190,079	111,154,724	155,344,803	0	155,344,803	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0006 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A | Date/Time Prepared: 5/31/2023 1:02 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	-79,466	2,336,716		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-299,860	11,291,668		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	8,543,796		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	749,161	34,652,992		5.00
7.00	00700	OPERATION OF PLANT	-46,520	9,050,364		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	511,464		8.00
9.00	00900	HOUSEKEEPING	0	1,870,439		9.00
10.00	01000	DIETARY	0	1,155,247		10.00
11.00	01100	CAFETERIA	0	1,888,817		11.00
13.00	01300	NURSING ADMINISTRATION	-126,544	3,024,851		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,654,684		14.00
15.00	01500	PHARMACY	0	1,886,970		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-18,354	1,241,579		16.00
17.00	01700	SOCIAL SERVICE	0	753,142		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-1,641,111	10,123,846		30.00
31.00	03100	INTENSIVE CARE UNIT	-537,659	3,816,364		31.00
40.00	04000	SUBPROVIDER - IPF	0	0		40.00
41.00	04100	SUBPROVIDER - IRF	0	0		41.00
43.00	04300	NURSERY	0	447,638		43.00
44.00	04400	SKILLED NURSING FACILITY	0	0		44.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-1,933,725	4,534,221		50.00
51.00	05100	RECOVERY ROOM	0	1,824,137		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	-65,303	926,600		52.00
53.00	05300	ANESTHESIOLOGY	-1,692,500	234,271		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-43,827	2,800,631		54.00
54.01	05401	ULTRASOUND	0	427,428		54.01
56.00	05600	RADIOISOTOPE	0	598,904		56.00
57.00	05700	CT SCAN	0	756,976		57.00
58.00	05800	MRI	0	394,892		58.00
60.00	06000	LABORATORY	0	5,084,603		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	579,259		62.00
65.00	06500	RESPIRATORY THERAPY	0	1,258,758		65.00
66.00	06600	PHYSICAL THERAPY	0	1,935,346		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	684,462		67.00
68.00	06800	SPEECH PATHOLOGY	0	685,332		68.00
69.00	06900	ELECTROCARDIOLOGY	0	4,066,229		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	-43,531	973,847		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	4,778,359		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-11,609	11,908,256		73.00
74.00	07400	RENAL DIALYSIS	0	520,295		74.00
76.00	03950	OTHER ANCILLARY-OTHER	0	0		76.00
76.01	03610	SLEEP LAB	0	345,830		76.01
76.02	03020	ACUPUNCTURE	0	0		76.02
76.03	03040	WOUND CARE	-14,475	856,274		76.03
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0		77.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	-4,351,825	0		90.00
91.00	09100	EMERGENCY	-121,638	4,161,246		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	0		95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0		102.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-10,278,786	144,586,733		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	260,953		192.00
194.00	07950	OTHER NONREIMBURSABLE COSTS	0	218,331		194.00
194.01	07951	MARKETING	0	0		194.01
200.00		TOTAL (SUM OF LINES 118 through 199)	-10,278,786	145,066,017		200.00

RECLASSIFICATIONS | Provider CCN: 15-0006 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-6 | Date/Time Prepared: 5/31/2023 1:02 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - EMPLOYEE BENEFITS				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	8,123,077	1.00
	0		0	8,123,077	
	B - RENTAL AND LEASE EXPENSES				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	3,930,006	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	354,802	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
	0		0	4,284,808	
	C - OTHER CAPITAL COSTS				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	395,277	1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	736,829	2.00
3.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	21,610	3.00
	0		0	1,153,716	
	D - REPAIRS AND MAINTENANCE				
1.00	OPERATION OF PLANT	7.00	0	3,298,946	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
	0		0	3,298,946	
	E - CHIEF NURSING OFFICER COSTS				
1.00	NURSING ADMINISTRATION	13.00	182,412	0	1.00
	0		182,412	0	
	F - MEDICAL SUPPLIES				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	1,017,378	1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	4,778,359	2.00
	0		0	5,795,737	

RECLASSIFICATIONS | Provider CCN: 15-0006 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-6 | Date/Time Prepared: 5/31/2023 1:02 pm

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	G - COST OF DRUGS/IV SOLUTIONS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	11,919,865		1.00
	0		0	11,919,865		
	H - LABOR AND DELIVERY COSTS					
1.00	ADULTS & PEDIATRICS	30.00	623,543	155,070		1.00
2.00	NURSERY	43.00	357,540	84,494		2.00
	0		981,083	239,564		
	I - CAFETERIA RECLASSIFICATION					
1.00	CAFETERIA	11.00	0	1,888,817		1.00
	0		0	1,888,817		
	J - NONCAPITALIZED EQUIPMENT					
1.00	OPERATION OF PLANT	7.00	0	375,525		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
	0		0	375,525		
	K - BLOOD BANK RECLASSIFICATION					
1.00	WHOLE BLOOD & PACKED RED BLOOD CELL	62.00	142,138	437,121		1.00
	0		142,138	437,121		
	L - MOB OVERHEAD					
1.00	OPERATION OF PLANT	7.00	0	997,570		1.00
2.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	1,095,104		2.00
	0		0	2,092,674		
500.00	Grand Total: Increases		1,305,633	39,609,850		500.00

RECLASSIFICATIONS | Provider CCN: 15-0006 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-6 | Date/Time Prepared: 5/31/2023 1:02 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - EMPLOYEE BENEFITS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	8,123,077	0		1.00
	0		0	8,123,077			
	B - RENTAL AND LEASE EXPENSES						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	2,872,488	10		1.00
2.00	OPERATION OF PLANT	7.00	0	27,728	10		2.00
3.00	HOUSEKEEPING	9.00	0	1,129	0		3.00
4.00	DIETARY	10.00	0	1,953	0		4.00
5.00	NURSING ADMINISTRATION	13.00	0	24,739	0		5.00
6.00	CENTRAL SERVICES & SUPPLY	14.00	0	16,316	0		6.00
7.00	PHARMACY	15.00	0	306,619	0		7.00
8.00	MEDICAL RECORDS & LIBRARY	16.00	0	300	0		8.00
9.00	ADULTS & PEDIATRICS	30.00	0	19,613	0		9.00
10.00	INTENSIVE CARE UNIT	31.00	0	27,327	0		10.00
11.00	OPERATING ROOM	50.00	0	682,168	0		11.00
12.00	RECOVERY ROOM	51.00	0	560	0		12.00
13.00	DELIVERY ROOM & LABOR ROOM	52.00	0	1,320	0		13.00
14.00	RADIOLOGY-DIAGNOSTIC	54.00	0	42,083	0		14.00
15.00	CT SCAN	57.00	0	7,209	0		15.00
16.00	LABORATORY	60.00	0	107,182	0		16.00
17.00	RESPIRATORY THERAPY	65.00	0	54,699	0		17.00
18.00	PHYSICAL THERAPY	66.00	0	457	0		18.00
19.00	ELECTROCARDIOLOGY	69.00	0	78,750	0		19.00
20.00	SLEEP LAB	76.01	0	5,277	0		20.00
21.00	WOUND CARE	76.03	0	1,133	0		21.00
22.00	EMERGENCY	91.00	0	2,216	0		22.00
23.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	3,542	0		23.00
	0		0	4,284,808			
	C - OTHER CAPITAL COSTS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	1,153,716	12		1.00
2.00		0.00	0	0	13		2.00
3.00		0.00	0	0	12		3.00
	0		0	1,153,716			
	D - REPAIRS AND MAINTENANCE						
1.00	OPERATION OF PLANT	7.00	0	7,238	0		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	236,948	0		2.00
3.00	HOUSEKEEPING	9.00	0	1,529	0		3.00
4.00	DIETARY	10.00	0	70,137	0		4.00
5.00	NURSING ADMINISTRATION	13.00	0	2,022	0		5.00
6.00	CENTRAL SERVICES & SUPPLY	14.00	0	135,113	0		6.00
7.00	PHARMACY	15.00	0	73,286	0		7.00
8.00	MEDICAL RECORDS & LIBRARY	16.00	0	40	0		8.00
9.00	ADULTS & PEDIATRICS	30.00	0	3,957	0		9.00
10.00	INTENSIVE CARE UNIT	31.00	0	8,688	0		10.00
11.00	OPERATING ROOM	50.00	0	598,820	0		11.00
12.00	RECOVERY ROOM	51.00	0	413	0		12.00
13.00	DELIVERY ROOM & LABOR ROOM	52.00	0	11,097	0		13.00
14.00	ANESTHESIOLOGY	53.00	0	16,818	0		14.00
15.00	RADIOLOGY-DIAGNOSTIC	54.00	0	739,131	0		15.00
16.00	ULTRASOUND	54.01	0	20,803	0		16.00
17.00	RADIOISOTOPE	56.00	0	57,540	0		17.00
18.00	CT SCAN	57.00	0	217,714	0		18.00
19.00	MRI	58.00	0	143,417	0		19.00
20.00	LABORATORY	60.00	0	103,931	0		20.00
21.00	RESPIRATORY THERAPY	65.00	0	7,829	0		21.00
22.00	PHYSICAL THERAPY	66.00	0	47,857	0		22.00
23.00	OCCUPATIONAL THERAPY	67.00	0	1,406	0		23.00
24.00	SPEECH PATHOLOGY	68.00	0	1,718	0		24.00
25.00	ELECTROCARDIOLOGY	69.00	0	617,988	0		25.00
26.00	SLEEP LAB	76.01	0	8,409	0		26.00
27.00	WOUND CARE	76.03	0	2,888	0		27.00
28.00	EMERGENCY	91.00	0	13,427	0		28.00
29.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	148,782	0		29.00
	0		0	3,298,946			
	E - CHIEF NURSING OFFICER COSTS						
1.00	ADMINISTRATIVE & GENERAL	5.00	182,412	0	0		1.00
	0		182,412	0			
	F - MEDICAL SUPPLIES						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	5,725,754	0		1.00
2.00	OPERATING ROOM	50.00	0	69,983	0		2.00
	0		0	5,795,737			

RECLASSIFICATIONS | Provider CCN: 15-0006 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-6 | Date/Time Prepared: 5/31/2023 1:02 pm

		Decreases				
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	G - COST OF DRUGS/IV SOLUTIONS					
1.00	PHARMACY	15.00	0	11,919,865	0	1.00
	0		0	11,919,865		
	H - LABOR AND DELIVERY COSTS					
1.00	DELIVERY ROOM & LABOR ROOM	52.00	981,083	239,564	0	1.00
2.00		0.00	0	0	0	2.00
	0		981,083	239,564		
	I - CAFETERIA RECLASSIFICATION					
1.00	DIETARY	10.00	0	1,888,817	0	1.00
	0		0	1,888,817		
	J - NONCAPITALIZED EQUIPMENT					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	3,700	0	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	39,974	0	2.00
3.00	HOUSEKEEPING	9.00	0	15,313	0	3.00
4.00	DIETARY	10.00	0	8,107	0	4.00
5.00	NURSING ADMINISTRATION	13.00	0	9,890	0	5.00
6.00	CENTRAL SERVICES & SUPPLY	14.00	0	24,011	0	6.00
7.00	PHARMACY	15.00	0	1,640	0	7.00
8.00	MEDICAL RECORDS & LIBRARY	16.00	0	1,585	0	8.00
9.00	SOCIAL SERVICE	17.00	0	5,404	0	9.00
10.00	ADULTS & PEDIATRICS	30.00	0	12,476	0	10.00
11.00	INTENSIVE CARE UNIT	31.00	0	2,507	0	11.00
12.00	OPERATING ROOM	50.00	0	137,703	0	12.00
13.00	RECOVERY ROOM	51.00	0	2,219	0	13.00
14.00	DELIVERY ROOM & LABOR ROOM	52.00	0	6,548	0	14.00
15.00	ANESTHESIOLOGY	53.00	0	1,347	0	15.00
16.00	RADIOLOGY-DIAGNOSTIC	54.00	0	17,205	0	16.00
17.00	ULTRASOUND	54.01	0	1,672	0	17.00
18.00	CT SCAN	57.00	0	875	0	18.00
19.00	MRI	58.00	0	705	0	19.00
20.00	LABORATORY	60.00	0	15,612	0	20.00
21.00	RESPIRATORY THERAPY	65.00	0	1,014	0	21.00
22.00	PHYSICAL THERAPY	66.00	0	22,632	0	22.00
23.00	SPEECH PATHOLOGY	68.00	0	8,773	0	23.00
24.00	ELECTROCARDIOLOGY	69.00	0	15,037	0	24.00
25.00	RENAL DIALYSIS	74.00	0	2,400	0	25.00
26.00	SLEEP LAB	76.01	0	3,836	0	26.00
27.00	WOUND CARE	76.03	0	2,630	0	27.00
28.00	EMERGENCY	91.00	0	6,786	0	28.00
29.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	2,388	0	29.00
30.00	OTHER NONREIMBURSABLE COSTS	194.00	0	1,536	0	30.00
	0		0	375,525		
	K - BLOOD BANK RECLASSIFICATION					
1.00	LABORATORY	60.00	142,138	437,121	0	1.00
	0		142,138	437,121		
	L - MOB OVERHEAD					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	2,092,674	10	1.00
2.00		0.00	0	0	0	2.00
	0		0	2,092,674		
500.00	Grand Total: Decreases		1,305,633	39,609,850		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0006 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-7 Part I | Date/Time Prepared: 5/31/2023 1:02 pm

		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	5,512,165	0	0	0	0	1.00
2.00	Land Improvements	991,803	0	0	0	15,272	2.00
3.00	Buildings and Fixtures	8,797,878	0	0	0	151,919	3.00
4.00	Building Improvements	2,060,720	0	0	0	1,052,313	4.00
5.00	Fixed Equipment	4,413,294	0	0	0	513,444	5.00
6.00	Movable Equipment	11,196,501	0	0	0	3,551,628	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	32,972,361	0	0	0	5,284,576	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	32,972,361	0	0	0	5,284,576	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	5,512,165	0	1.00
2.00	Land Improvements	976,531	0	2.00
3.00	Buildings and Fixtures	8,645,959	0	3.00
4.00	Building Improvements	1,008,407	0	4.00
5.00	Fixed Equipment	3,899,850	0	5.00
6.00	Movable Equipment	7,644,873	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	27,687,785	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	27,687,785	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0006 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-7 Part II | Date/Time Prepared: 5/31/2023 1:02 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	2,499,728	-3,052,984	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	11,215,116	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	13,714,844	-3,052,984	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL			
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)		
		14.00	15.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2				
1.00	CAP REL COSTS-BLDG & FIXT	0	-553,256		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	11,215,116		2.00
3.00	Total (sum of lines 1-2)	0	10,661,860		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0006 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-7 Part III Date/Time Prepared: 5/31/2023 1:02 pm

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	16,143,062	0	16,143,062	0.583039	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	11,544,723	0	11,544,723	0.416961	0	2.00
3.00	Total (sum of lines 1-2)	27,687,785	0	27,687,785	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	2,506,095	-1,215,652	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	10,662,860	329,999	2.00
3.00	Total (sum of lines 1-2)	0	0	0	13,168,955	-885,653	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	-85,833	395,277	736,829	0	2,336,716	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	277,199	21,610	0	0	11,291,668	2.00
3.00	Total (sum of lines 1-2)	191,366	416,887	736,829	0	13,628,384	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0006 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-8 | Date/Time Prepared: 5/31/2023 1:02 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	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)	A	0	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-46,520	OPERATION OF PLANT	7.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-12,210,940			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)	B	-1,259	RADIOLOGY-DIAGNOSTIC	54.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	-1,574,701			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	B	-43,531	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	16.00
17.00	Sale of drugs to other than patients	B	-11,609	DRUGS CHARGED TO PATIENTS	73.00	0	17.00
18.00	Sale of medical records and abstracts	B	-18,354	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines	B	-1,180	ADMINISTRATIVE & GENERAL	5.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT	A	6,367	CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	A	-552,256	CAP REL COSTS-MVBLE EQUIP	2.00	9	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	TRAINING REVENUE	B	-126,544	NURSING ADMINISTRATION	13.00	0	33.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0006 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-8 | Date/Time Prepared: 5/31/2023 1:02 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
34.00	TELEPHONE COMMISSION	B	-27,867	ADMINISTRATIVE & GENERAL	5.00	0	34.00
35.00	MISC NON-PATIENT REVENUE	B	-65,327	ADMINISTRATIVE & GENERAL	5.00	0	35.00
36.00	RENTAL INCOME	B	-225,722	CAP REL COSTS-BLDG & FIXT	1.00	11	36.00
37.00	OTHER MISCELLANEOUS REVENUE	B	-317,018	ADMINISTRATIVE & GENERAL	5.00	0	37.00
38.00	PATIENT TELEPHONE BENEFIT COST	A	0	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	38.00
39.00	MARKETING EXPENSE	A	-291,068	ADMINISTRATIVE & GENERAL	5.00	0	39.00
40.00	MGMT FEE AND MOB GAIN/LOSS	A	5,601,764	ADMINISTRATIVE & GENERAL	5.00	0	40.00
41.00	PHYSICIAN RECRUITING	A	-236,343	ADMINISTRATIVE & GENERAL	5.00	0	41.00
41.04	NONALLOWABLE EXPENSE - LOBBYING	A	-18	ADMINISTRATIVE & GENERAL	5.00	0	41.04
42.00	CHARITABLE CONTRIBUTIONS	A	-26,000	ADMINISTRATIVE & GENERAL	5.00	0	42.00
45.00	LEGAL FEES	A	-43,391	ADMINISTRATIVE & GENERAL	5.00	0	45.00
45.02	PATIENT TELEPHONE DEPRECIATION	A	0	CAP REL COSTS-MVBLE EQUIP	2.00	10	45.02
45.04	ACCREDIDATION FEES	A	-10,379	ADMINISTRATIVE & GENERAL	5.00	0	45.04
45.09	PATIENT TV DEPRECIATION	A	-24,803	CAP REL COSTS-MVBLE EQUIP	2.00	10	45.09
45.10	PATIENT PHONE WAGES	A	0	ADMINISTRATIVE & GENERAL	5.00	0	45.10
45.12	LOBBYING EXPENSE IN ASSOCIATION DUES	A	-32,087	ADMINISTRATIVE & GENERAL	5.00	0	45.12
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-10,278,786				50.00

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 15-0006 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-8-1 | Date/Time Prepared: 5/31/2023 1:02 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	0.00			0	0	1.00
2.00	0.00			0	0	2.00
3.00	0.00			0	0	3.00
4.00	1.00	CAP REL COSTS-BLDG & FIXT	PASI Capital Costs - Bldg &	8,770	0	4.00
4.01	2.00	CAP REL COSTS-MVBLE EQUIP	PASI Capital Costs - Moveabl	1,832	0	4.01
4.02	5.00	ADMINISTRATIVE & GENERAL	PASI Operating Costs	626,441	502,753	4.02
4.03	5.00	ADMINISTRATIVE & GENERAL	Shared Service Center Alloca	3,056,206	1,701,000	4.03
4.04	1.00	CAP REL COSTS-BLDG & FIXT	New Capital - Building & Fix	131,119	0	4.04
4.05	2.00	CAP REL COSTS-MVBLE EQUIP	New Capital - Movable Equipm	275,367	0	4.05
4.06	5.00	ADMINISTRATIVE & GENERAL	Non-Capital Home Office Cost	5,125,361	0	4.06
4.07	5.00	ADMINISTRATIVE & GENERAL	Malpractice Costs	176,002	714,642	4.07
4.08	5.00	ADMINISTRATIVE & GENERAL	Interest Expense	0	590,616	4.08
4.09	5.00	ADMINISTRATIVE & GENERAL	Management Fees	0	3,978,469	4.09
4.10	5.00	ADMINISTRATIVE & GENERAL	401K Fees	0	4,900	4.10
4.11	5.00	ADMINISTRATIVE & GENERAL	Audit Fees	0	129,679	4.11
4.12	5.00	ADMINISTRATIVE & GENERAL	Corporate Overhead Allocatio	0	2,661,413	4.12
4.13	5.00	ADMINISTRATIVE & GENERAL	HIIM Allocation	0	531,996	4.13
4.14	5.00	ADMINISTRATIVE & GENERAL	Contract Management	0	122,130	4.14
4.15	5.00	ADMINISTRATIVE & GENERAL	PASI Lien Unit Collection Fe	0	38,201	4.15
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			9,401,098	10,975,799	5.00

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

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

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

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

6.00	B		0.00	CHS	100.00	6.00
7.00	B		0.00	PASI	100.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 15-0006	Period: From 01/01/2022 To 12/31/2022	Worksheet A-8-1 Date/Time Prepared: 5/31/2023 1:02 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	0	0		1.00
2.00	0	0		2.00
3.00	0	0		3.00
4.00	8,770	11		4.00
4.01	1,832	11		4.01
4.02	123,688	11		4.02
4.03	1,355,206	0		4.03
4.04	131,119	11		4.04
4.05	275,367	11		4.05
4.06	5,125,361	0		4.06
4.07	-538,640	0		4.07
4.08	-590,616	0		4.08
4.09	-3,978,469	0		4.09
4.10	-4,900	0		4.10
4.11	-129,679	0		4.11
4.12	-2,661,413	0		4.12
4.13	-531,996	0		4.13
4.14	-122,130	0		4.14
4.15	-38,201	0		4.15
5.00	-1,574,701			5.00

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

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

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

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

6.00	HEALTHCARE		6.00
7.00	COLLECTION UNIT		7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-0006 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-8-2 | Date/Time Prepared: 5/31/2023 1:02 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	1,810,136	1,810,136	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	1,641,111	1,641,111	0	0	0	2.00
3.00	31.00	INTENSIVE CARE UNIT	537,659	537,659	0	0	0	3.00
4.00	50.00	OPERATING ROOM	1,933,725	1,933,725	0	0	0	4.00
5.00	52.00	DELIVERY ROOM & LABOR ROOM	65,303	65,303	0	0	0	5.00
6.00	53.00	ANESTHESIOLOGY	1,692,500	1,692,500	0	0	0	6.00
7.00	54.00	RADIOLOGY-DIAGNOSTIC	42,568	42,568	0	0	0	7.00
8.00	76.03	WOUND CARE	14,475	14,475	0	0	0	8.00
9.00	90.00	CLINIC	4,351,825	4,351,825	0	0	0	9.00
10.00	91.00	EMERGENCY	121,638	121,638	0	0	0	10.00
200.00			12,210,940	12,210,940	0		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	31.00	INTENSIVE CARE UNIT	0	0	0	0	0	3.00
4.00	50.00	OPERATING ROOM	0	0	0	0	0	4.00
5.00	52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	5.00
6.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	6.00
7.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	7.00
8.00	76.03	WOUND CARE	0	0	0	0	0	8.00
9.00	90.00	CLINIC	0	0	0	0	0	9.00
10.00	91.00	EMERGENCY	0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	1,810,136		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	1,641,111		2.00
3.00	31.00	INTENSIVE CARE UNIT	0	0	0	537,659		3.00
4.00	50.00	OPERATING ROOM	0	0	0	1,933,725		4.00
5.00	52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	65,303		5.00
6.00	53.00	ANESTHESIOLOGY	0	0	0	1,692,500		6.00
7.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	42,568		7.00
8.00	76.03	WOUND CARE	0	0	0	14,475		8.00
9.00	90.00	CLINIC	0	0	0	4,351,825		9.00
10.00	91.00	EMERGENCY	0	0	0	121,638		10.00
200.00			0	0	0	12,210,940		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0006 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part I Date/Time Prepared: 5/31/2023 1:02 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	2,336,716	2,336,716				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	11,291,668		11,291,668			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	8,543,796	6,822	32,967	8,583,585		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	34,652,992	92,236	445,708	1,441,384	36,632,320	5.00
7.00	00700	OPERATION OF PLANT	9,050,364	1,460,820	7,059,097	206,948	17,777,229	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	511,464	2,385	11,523	0	525,372	8.00
9.00	00900	HOUSEKEEPING	1,870,439	8,485	41,000	0	1,919,924	9.00
10.00	01000	DIETARY	1,155,247	13,330	64,415	0	1,232,992	10.00
11.00	01100	CAFETERIA	1,888,817	8,433	40,750	0	1,938,000	11.00
13.00	01300	NURSING ADMINISTRATION	3,024,851	6,287	30,379	512,274	3,573,791	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,654,684	17,232	83,270	118,584	1,873,770	14.00
15.00	01500	PHARMACY	1,886,970	11,329	54,745	302,009	2,255,053	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,241,579	2,851	13,778	103,783	1,361,991	16.00
17.00	01700	SOCIAL SERVICE	753,142	2,098	10,137	89,284	854,661	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	10,123,846	128,514	621,015	1,319,916	12,193,291	30.00
31.00	03100	INTENSIVE CARE UNIT	3,816,364	39,696	191,824	488,332	4,536,216	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	447,638	377	1,820	69,877	519,712	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,534,221	81,390	393,301	450,012	5,458,924	50.00
51.00	05100	RECOVERY ROOM	1,824,137	7,949	38,412	282,690	2,153,188	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	926,600	52,546	253,917	153,768	1,386,831	52.00
53.00	05300	ANESTHESIOLOGY	234,271	1,272	6,146	9,665	251,354	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,800,631	77,931	376,584	414,431	3,669,577	54.00
54.01	05401	ULTRASOUND	427,428	2,392	11,557	74,680	516,057	54.01
56.00	05600	RADIOISOTOPE	598,904	3,919	18,939	66,764	688,526	56.00
57.00	05700	CT SCAN	756,976	3,943	19,055	121,476	901,450	57.00
58.00	05800	MRI	394,892	4,655	22,496	35,364	457,407	58.00
60.00	06000	LABORATORY	5,084,603	26,864	129,814	441,252	5,682,533	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	579,259	1,382	6,680	27,779	615,100	62.00
65.00	06500	RESPIRATORY THERAPY	1,258,758	3,971	19,189	201,677	1,483,595	65.00
66.00	06600	PHYSICAL THERAPY	1,935,346	69,253	334,648	336,059	2,675,306	66.00
67.00	06700	OCCUPATIONAL THERAPY	684,462	18,718	90,451	118,990	912,621	67.00
68.00	06800	SPEECH PATHOLOGY	685,332	12,625	61,008	106,398	865,363	68.00
69.00	06900	ELECTROCARDIOLOGY	4,066,229	74,188	358,497	557,112	5,056,026	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	973,847	0	0	0	973,847	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,778,359	0	0	0	4,778,359	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	11,908,256	0	0	0	11,908,256	73.00
74.00	07400	RENAL DIALYSIS	520,295	919	4,442	12,140	537,796	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	345,830	26,124	126,240	55,584	553,778	76.01
76.02	03020	ACUPUNCTURE	0	0	0	0	0	76.02
76.03	03040	WOUND CARE	856,274	16,009	77,358	1,197	950,838	76.03
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	4,161,246	47,200	228,081	425,249	4,861,776	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	144,586,733	2,334,145	11,279,243	8,544,678	144,532,830	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	2,571	12,425	0	14,996	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	260,953	0	0	23,252	284,205	192.00
194.00	07950	OTHER NONREIMBURSABLE COSTS	218,331	0	0	15,655	233,986	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
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)	145,066,017	2,336,716	11,291,668	8,583,585	145,066,017	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0006 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part I | Date/Time Prepared: 5/31/2023 1:02 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	36,632,320					5.00
7.00	00700	OPERATION OF PLANT	6,005,663	23,782,892				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	177,487	73,007	775,866			8.00
9.00	00900	HOUSEKEEPING	648,612	259,758	0	2,828,294		9.00
10.00	01000	DIETARY	416,544	408,100	0	49,220	2,106,856	10.00
11.00	01100	CAFETERIA	654,718	258,170	0	31,138	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,207,341	192,464	0	23,213	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	633,019	527,556	0	63,628	0	14.00
15.00	01500	PHARMACY	761,829	346,837	0	41,832	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	460,124	87,291	0	10,528	0	16.00
17.00	01700	SOCIAL SERVICE	288,732	64,225	0	7,746	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,119,284	3,934,453	340,605	474,529	1,417,375	30.00
31.00	03100	INTENSIVE CARE UNIT	1,532,479	1,215,306	62,846	146,577	144,633	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	175,575	11,533	0	1,391	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,844,199	2,491,768	102,414	300,529	0	50.00
51.00	05100	RECOVERY ROOM	727,416	243,357	27,155	29,351	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	468,516	1,608,698	0	194,023	0	52.00
53.00	05300	ANESTHESIOLOGY	84,915	38,937	0	4,696	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,239,701	2,385,854	65,172	287,755	0	54.00
54.01	05401	ULTRASOUND	174,341	73,219	0	8,831	0	54.01
56.00	05600	RADIOISOTOPE	232,606	119,986	0	14,471	0	56.00
57.00	05700	CT SCAN	304,539	120,726	0	14,561	0	57.00
58.00	05800	MRI	154,527	142,523	0	17,190	0	58.00
60.00	06000	LABORATORY	1,919,741	822,442	0	99,194	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	207,800	42,323	0	5,105	0	62.00
65.00	06500	RESPIRATORY THERAPY	501,206	121,573	0	14,663	0	65.00
66.00	06600	PHYSICAL THERAPY	903,804	2,120,172	0	255,712	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	308,313	573,054	0	69,115	0	67.00
68.00	06800	SPEECH PATHOLOGY	292,347	386,515	0	46,617	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,708,087	2,271,265	28,707	273,935	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	328,997	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,614,283	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,022,990	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	181,685	28,145	0	3,395	0	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	187,084	799,799	1,552	96,463	0	76.01
76.02	03020	ACUPUNCTURE	0	0	0	0	0	76.02
76.03	03040	WOUND CARE	321,224	490,101	0	59,110	0	76.03
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	1,642,464	1,445,014	147,415	174,282	84,945	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	36,452,192	23,704,171	775,866	2,818,800	1,646,953	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	5,066	78,721	0	9,494	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	96,014	0	0	0	458,853	192.00
194.00	07950	OTHER NONREIMBURSABLE COSTS	79,048	0	0	0	1,050	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
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)	36,632,320	23,782,892	775,866	2,828,294	2,106,856	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0006 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part I | Date/Time Prepared: 5/31/2023 1:02 pm

		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	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	2,882,026					11.00
13.00	01300	NURSING ADMINISTRATION	183,532	5,180,341				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	78,992	59	3,177,024			14.00
15.00	01500	PHARMACY	96,784	0	12,266	3,514,601		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	61,720	0	1,771	0	1,983,425	16.00
17.00	01700	SOCIAL SERVICE	43,211	0	459	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	517,879	1,772,306	150,460	0	143,445	30.00
31.00	03100	INTENSIVE CARE UNIT	172,322	793,954	76,424	0	36,075	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	41,386	0	0	0	6,063	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	210,645	373,169	408,271	0	320,428	50.00
51.00	05100	RECOVERY ROOM	108,060	413,723	50,228	0	49,920	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	91,114	589,556	52,942	0	12,778	52.00
53.00	05300	ANESTHESIOLOGY	7,104	0	47,370	0	78,081	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	160,004	172,561	32,758	0	40,613	54.00
54.01	05401	ULTRASOUND	23,398	895	4,133	0	21,099	54.01
56.00	05600	RADIOISOTOPE	20,595	215	53,150	0	29,615	56.00
57.00	05700	CT SCAN	52,140	11,433	16,504	0	91,002	57.00
58.00	05800	MRI	13,230	3,871	4,693	0	30,735	58.00
60.00	06000	LABORATORY	279,665	0	389,679	0	221,785	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	11,210	0	108,823	0	4,958	62.00
65.00	06500	RESPIRATORY THERAPY	85,053	0	16,590	0	29,389	65.00
66.00	06600	PHYSICAL THERAPY	139,083	0	4,470	0	38,214	66.00
67.00	06700	OCCUPATIONAL THERAPY	33,109	0	585	0	19,692	67.00
68.00	06800	SPEECH PATHOLOGY	56,441	0	799	0	12,775	68.00
69.00	06900	ELECTROCARDIOLOGY	206,408	379,482	102,662	0	130,468	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	218,766	0	44,374	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	1,298,105	0	82,031	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	3,514,601	402,918	73.00
74.00	07400	RENAL DIALYSIS	3,650	458	7,572	0	12,742	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	29,198	0	5,508	0	10,209	76.01
76.02	03020	ACUPUNCTURE	0	0	0	0	0	76.02
76.03	03040	WOUND CARE	456	0	24,933	0	5,160	76.03
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	136,671	659,234	85,629	0	108,856	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,863,060	5,170,916	3,175,550	3,514,601	1,983,425	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	10,493	9,425	1,474	0	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COSTS	8,473	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
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)	2,882,026	5,180,341	3,177,024	3,514,601	1,983,425	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0006 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part I | Date/Time Prepared: 5/31/2023 1:02 pm

		Cost Center Description	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			17.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	1,259,034					17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	990,014	26,053,641	0	26,053,641		30.00
31.00	03100	INTENSIVE CARE UNIT	189,700	8,906,532	0	8,906,532		31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0		40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0		41.00
43.00	04300	NURSERY	79,320	834,980	0	834,980		43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0		44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	11,510,347	0	11,510,347		50.00
51.00	05100	RECOVERY ROOM	0	3,802,398	0	3,802,398		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	4,404,458	0	4,404,458		52.00
53.00	05300	ANESTHESIOLOGY	0	512,457	0	512,457		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	8,053,995	0	8,053,995		54.00
54.01	05401	ULTRASOUND	0	821,973	0	821,973		54.01
56.00	05600	RADIOISOTOPE	0	1,159,164	0	1,159,164		56.00
57.00	05700	CT SCAN	0	1,512,355	0	1,512,355		57.00
58.00	05800	MRI	0	824,176	0	824,176		58.00
60.00	06000	LABORATORY	0	9,415,039	0	9,415,039		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	995,319	0	995,319		62.00
65.00	06500	RESPIRATORY THERAPY	0	2,252,069	0	2,252,069		65.00
66.00	06600	PHYSICAL THERAPY	0	6,136,761	0	6,136,761		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,916,489	0	1,916,489		67.00
68.00	06800	SPEECH PATHOLOGY	0	1,660,857	0	1,660,857		68.00
69.00	06900	ELECTROCARDIOLOGY	0	10,157,040	0	10,157,040		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,565,984	0	1,565,984		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	7,772,778	0	7,772,778		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	19,848,765	0	19,848,765		73.00
74.00	07400	RENAL DIALYSIS	0	775,443	0	775,443		74.00
76.00	03950	OTHER ANCILLARY-OTHER	0	0	0	0		76.00
76.01	03610	SLEEP LAB	0	1,683,591	0	1,683,591		76.01
76.02	03020	ACUPUNCTURE	0	0	0	0		76.02
76.03	03040	WOUND CARE	0	1,851,822	0	1,851,822		76.03
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0		77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0		90.00
91.00	09100	EMERGENCY	0	9,346,286	0	9,346,286		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0		95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0		102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,259,034	143,774,719	0	143,774,719		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	108,277	0	108,277		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	860,464	0	860,464		192.00
194.00	07950	OTHER NONREIMBURSABLE COSTS	0	322,557	0	322,557		194.00
194.01	07951	MARKETING	0	0	0	0		194.01
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	1,259,034	145,066,017	0	145,066,017		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0006 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part II Date/Time Prepared: 5/31/2023 1:02 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	6,822	32,967	39,789	39,789	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	92,236	445,708	537,944	6,677	5.00
7.00	00700	OPERATION OF PLANT	0	1,460,820	7,059,097	8,519,917	959	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	2,385	11,523	13,908	0	8.00
9.00	00900	HOUSEKEEPING	0	8,485	41,000	49,485	0	9.00
10.00	01000	DIETARY	0	13,330	64,415	77,745	0	10.00
11.00	01100	CAFETERIA	0	8,433	40,750	49,183	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	6,287	30,379	36,666	2,375	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	17,232	83,270	100,502	550	14.00
15.00	01500	PHARMACY	0	11,329	54,745	66,074	1,400	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	2,851	13,778	16,629	481	16.00
17.00	01700	SOCIAL SERVICE	0	2,098	10,137	12,235	414	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	128,514	621,015	749,529	6,119	30.00
31.00	03100	INTENSIVE CARE UNIT	0	39,696	191,824	231,520	2,264	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	0	377	1,820	2,197	324	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	81,390	393,301	474,691	2,086	50.00
51.00	05100	RECOVERY ROOM	0	7,949	38,412	46,361	1,310	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	52,546	253,917	306,463	713	52.00
53.00	05300	ANESTHESIOLOGY	0	1,272	6,146	7,418	45	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	77,931	376,584	454,515	1,921	54.00
54.01	05401	ULTRASOUND	0	2,392	11,557	13,949	346	54.01
56.00	05600	RADIOISOTOPE	0	3,919	18,939	22,858	310	56.00
57.00	05700	CT SCAN	0	3,943	19,055	22,998	563	57.00
58.00	05800	MRI	0	4,655	22,496	27,151	164	58.00
60.00	06000	LABORATORY	0	26,864	129,814	156,678	2,046	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	1,382	6,680	8,062	129	62.00
65.00	06500	RESPIRATORY THERAPY	0	3,971	19,189	23,160	935	65.00
66.00	06600	PHYSICAL THERAPY	0	69,253	334,648	403,901	1,558	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	18,718	90,451	109,169	552	67.00
68.00	06800	SPEECH PATHOLOGY	0	12,625	61,008	73,633	493	68.00
69.00	06900	ELECTROCARDIOLOGY	0	74,188	358,497	432,685	2,583	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	919	4,442	5,361	56	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	26,124	126,240	152,364	258	76.01
76.02	03020	ACUPUNCTURE	0	0	0	0	0	76.02
76.03	03040	WOUND CARE	0	16,009	77,358	93,367	6	76.03
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	47,200	228,081	275,281	1,971	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	2,334,145	11,279,243	13,613,388	39,608	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	2,571	12,425	14,996	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	108	192.00
194.00	07950	OTHER NONREIMBURSABLE COSTS	0	0	0	0	73	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
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	2,336,716	11,291,668	13,628,384	39,789	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0006 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part II Date/Time Prepared: 5/31/2023 1:02 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	544,621					5.00
7.00	00700	OPERATION OF PLANT	89,254	8,610,130				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,639	26,431	42,978			8.00
9.00	00900	HOUSEKEEPING	9,644	94,040	0	153,169		9.00
10.00	01000	DIETARY	6,193	147,745	0	2,666	234,349	10.00
11.00	01100	CAFETERIA	9,735	93,466	0	1,686	0	11.00
13.00	01300	NURSING ADMINISTRATION	17,951	69,678	0	1,257	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	9,412	190,991	0	3,446	0	14.00
15.00	01500	PHARMACY	11,327	125,566	0	2,265	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	6,841	31,602	0	570	0	16.00
17.00	01700	SOCIAL SERVICE	4,293	23,251	0	419	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	61,247	1,424,391	18,868	25,700	157,656	30.00
31.00	03100	INTENSIVE CARE UNIT	22,785	439,978	3,481	7,938	16,088	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	2,611	4,175	0	75	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	27,420	902,096	5,673	16,275	0	50.00
51.00	05100	RECOVERY ROOM	10,815	88,103	1,504	1,590	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	6,966	582,398	0	10,508	0	52.00
53.00	05300	ANESTHESIOLOGY	1,263	14,096	0	254	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	18,432	863,752	3,610	15,584	0	54.00
54.01	05401	ULTRASOUND	2,592	26,507	0	478	0	54.01
56.00	05600	RADIOISOTOPE	3,458	43,438	0	784	0	56.00
57.00	05700	CT SCAN	4,528	43,707	0	789	0	57.00
58.00	05800	MRI	2,298	51,598	0	931	0	58.00
60.00	06000	LABORATORY	28,543	297,749	0	5,372	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	3,090	15,322	0	276	0	62.00
65.00	06500	RESPIRATORY THERAPY	7,452	44,013	0	794	0	65.00
66.00	06600	PHYSICAL THERAPY	13,438	767,567	0	13,848	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,584	207,463	0	3,743	0	67.00
68.00	06800	SPEECH PATHOLOGY	4,347	139,930	0	2,525	0	68.00
69.00	06900	ELECTROCARDIOLOGY	25,396	822,267	1,590	14,835	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,892	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	24,002	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	59,815	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	2,701	10,189	0	184	0	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	2,782	289,552	86	5,224	0	76.01
76.02	03020	ACUPUNCTURE	0	0	0	0	0	76.02
76.03	03040	WOUND CARE	4,776	177,431	0	3,201	0	76.03
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	24,421	523,139	8,166	9,438	9,449	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	541,943	8,581,631	42,978	152,655	183,193	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	75	28,499	0	514	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,428	0	0	0	51,039	192.00
194.00	07950	OTHER NONREIMBURSABLE COSTS	1,175	0	0	0	117	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
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)	544,621	8,610,130	42,978	153,169	234,349	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0006 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part II | Date/Time Prepared: 5/31/2023 1:02 pm

		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	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	154,070					11.00
13.00	01300	NURSING ADMINISTRATION	9,811	137,738				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	4,223	2	309,126			14.00
15.00	01500	PHARMACY	5,174	0	1,193	212,999		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,300	0	172	0	59,595	16.00
17.00	01700	SOCIAL SERVICE	2,310	0	45	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	27,686	47,122	14,640	0	4,296	30.00
31.00	03100	INTENSIVE CARE UNIT	9,212	21,110	7,436	0	1,080	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	2,212	0	0	0	182	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	11,261	9,922	39,725	0	9,596	50.00
51.00	05100	RECOVERY ROOM	5,777	11,000	4,887	0	1,495	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,871	15,676	5,151	0	383	52.00
53.00	05300	ANESTHESIOLOGY	380	0	4,609	0	2,338	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,554	4,588	3,187	0	1,216	54.00
54.01	05401	ULTRASOUND	1,251	24	402	0	632	54.01
56.00	05600	RADIOISOTOPE	1,101	6	5,172	0	887	56.00
57.00	05700	CT SCAN	2,787	304	1,606	0	2,725	57.00
58.00	05800	MRI	707	103	457	0	920	58.00
60.00	06000	LABORATORY	14,951	0	37,916	0	6,642	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	599	0	10,589	0	148	62.00
65.00	06500	RESPIRATORY THERAPY	4,547	0	1,614	0	880	65.00
66.00	06600	PHYSICAL THERAPY	7,435	0	435	0	1,144	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,770	0	57	0	590	67.00
68.00	06800	SPEECH PATHOLOGY	3,017	0	78	0	383	68.00
69.00	06900	ELECTROCARDIOLOGY	11,034	10,090	9,989	0	3,907	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	21,286	0	1,329	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	126,306	0	2,457	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	212,999	12,262	73.00
74.00	07400	RENAL DIALYSIS	195	12	737	0	382	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	1,561	0	536	0	306	76.01
76.02	03020	ACUPUNCTURE	0	0	0	0	0	76.02
76.03	03040	WOUND CARE	24	0	2,426	0	155	76.03
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	7,306	17,528	8,332	0	3,260	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	153,056	137,487	308,983	212,999	59,595	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	561	251	143	0	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COSTS	453	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
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)	154,070	137,738	309,126	212,999	59,595	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0006 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part II | Date/Time Prepared: 5/31/2023 1:02 pm

		Cost Center Description	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			17.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	42,967					17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	33,786	2,571,040	0	2,571,040		30.00
31.00	03100	INTENSIVE CARE UNIT	6,474	769,366	0	769,366		31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0		40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0		41.00
43.00	04300	NURSERY	2,707	14,483	0	14,483		43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0		44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,498,745	0	1,498,745		50.00
51.00	05100	RECOVERY ROOM	0	172,842	0	172,842		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	933,129	0	933,129		52.00
53.00	05300	ANESTHESIOLOGY	0	30,403	0	30,403		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,375,359	0	1,375,359		54.00
54.01	05401	ULTRASOUND	0	46,181	0	46,181		54.01
56.00	05600	RADIOISOTOPE	0	78,014	0	78,014		56.00
57.00	05700	CT SCAN	0	80,007	0	80,007		57.00
58.00	05800	MRI	0	84,329	0	84,329		58.00
60.00	06000	LABORATORY	0	549,897	0	549,897		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	38,215	0	38,215		62.00
65.00	06500	RESPIRATORY THERAPY	0	83,395	0	83,395		65.00
66.00	06600	PHYSICAL THERAPY	0	1,209,326	0	1,209,326		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	327,928	0	327,928		67.00
68.00	06800	SPEECH PATHOLOGY	0	224,406	0	224,406		68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,334,376	0	1,334,376		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	27,507	0	27,507		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	152,765	0	152,765		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	285,076	0	285,076		73.00
74.00	07400	RENAL DIALYSIS	0	19,817	0	19,817		74.00
76.00	03950	OTHER ANCILLARY-OTHER	0	0	0	0		76.00
76.01	03610	SLEEP LAB	0	452,669	0	452,669		76.01
76.02	03020	ACUPUNCTURE	0	0	0	0		76.02
76.03	03040	WOUND CARE	0	281,386	0	281,386		76.03
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0		77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0		90.00
91.00	09100	EMERGENCY	0	888,291	0	888,291		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0		95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0		102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	42,967	13,528,952	0	13,528,952		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	44,084	0	44,084		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	53,530	0	53,530		192.00
194.00	07950	OTHER NONREIMBURSABLE COSTS	0	1,818	0	1,818		194.00
194.01	07951	MARKETING	0	0	0	0		194.01
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	42,967	13,628,384	0	13,628,384		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0006 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B-1 | Date/Time Prepared: 5/31/2023 1:02 pm

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	676,120					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		676,120				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,974	1,974	43,920,054			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	26,688	26,688	7,375,267	-36,632,320	108,433,697	5.00
7.00	00700	OPERATION OF PLANT	422,683	422,683	1,058,901	0	17,777,229	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	690	690	0	0	525,372	8.00
9.00	00900	HOUSEKEEPING	2,455	2,455	0	0	1,919,924	9.00
10.00	01000	DIETARY	3,857	3,857	0	0	1,232,992	10.00
11.00	01100	CAFETERIA	2,440	2,440	0	0	1,938,000	11.00
13.00	01300	NURSING ADMINISTRATION	1,819	1,819	2,621,173	0	3,573,791	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	4,986	4,986	606,762	0	1,873,770	14.00
15.00	01500	PHARMACY	3,278	3,278	1,545,300	0	2,255,053	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	825	825	531,033	0	1,361,991	16.00
17.00	01700	SOCIAL SERVICE	607	607	456,842	0	854,661	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	37,185	37,185	6,753,667	0	12,193,291	30.00
31.00	03100	INTENSIVE CARE UNIT	11,486	11,486	2,498,668	0	4,536,216	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	109	109	357,540	0	519,712	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	23,550	23,550	2,302,595	0	5,458,924	50.00
51.00	05100	RECOVERY ROOM	2,300	2,300	1,446,453	0	2,153,188	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	15,204	15,204	786,793	0	1,386,831	52.00
53.00	05300	ANESTHESIOLOGY	368	368	49,455	0	251,354	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	22,549	22,549	2,120,537	0	3,669,577	54.00
54.01	05401	ULTRASOUND	692	692	382,120	0	516,057	54.01
56.00	05600	RADIOISOTOPE	1,134	1,134	341,616	0	688,526	56.00
57.00	05700	CT SCAN	1,141	1,141	621,560	0	901,450	57.00
58.00	05800	MRI	1,347	1,347	180,950	0	457,407	58.00
60.00	06000	LABORATORY	7,773	7,773	2,257,770	0	5,682,533	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	400	400	142,138	0	615,100	62.00
65.00	06500	RESPIRATORY THERAPY	1,149	1,149	1,031,929	0	1,483,595	65.00
66.00	06600	PHYSICAL THERAPY	20,038	20,038	1,719,528	0	2,675,306	66.00
67.00	06700	OCCUPATIONAL THERAPY	5,416	5,416	608,842	0	912,621	67.00
68.00	06800	SPEECH PATHOLOGY	3,653	3,653	544,410	0	865,363	68.00
69.00	06900	ELECTROCARDIOLOGY	21,466	21,466	2,850,595	0	5,056,026	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	973,847	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	4,778,359	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	11,908,256	73.00
74.00	07400	RENAL DIALYSIS	266	266	62,116	0	537,796	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	7,559	7,559	284,408	0	553,778	76.01
76.02	03020	ACUPUNCTURE	0	0	0	0	0	76.02
76.03	03040	WOUND CARE	4,632	4,632	6,124	0	950,838	76.03
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	13,657	13,657	2,175,886	0	4,861,776	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	675,376	675,376	43,720,978	-36,632,320	107,900,510	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	744	744	0	0	14,996	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	118,975	0	284,205	192.00
194.00	07950	OTHER NONREIMBURSABLE COSTS	0	0	80,101	0	233,986	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
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)	2,336,716	11,291,668	8,583,585		36,632,320	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	3.456067	16.700686	0.195437		0.337832	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			39,789		544,621	204.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0006 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B-1 | Date/Time Prepared: 5/31/2023 1:02 pm

	Cost Center Description	CAPITAL RELATED COSTS					
		BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
		1.00	2.00	4.00	5A	5.00	
205.00	Unit cost multiplier (Wkst. B, Part II)			0.000906		0.005023	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: 15-0006 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B-1 | Date/Time Prepared: 5/31/2023 1:02 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (HOURS)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	224,775					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	690	620,836				8.00
9.00	00900	HOUSEKEEPING	2,455	0	221,630			9.00
10.00	01000	DIETARY	3,857	0	3,857	76,243		10.00
11.00	01100	CAFETERIA	2,440	0	2,440	0	44,220	11.00
13.00	01300	NURSING ADMINISTRATION	1,819	0	1,819	0	2,816	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	4,986	0	4,986	0	1,212	14.00
15.00	01500	PHARMACY	3,278	0	3,278	0	1,485	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	825	0	825	0	947	16.00
17.00	01700	SOCIAL SERVICE	607	0	607	0	663	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	37,185	272,547	37,185	51,292	7,946	30.00
31.00	03100	INTENSIVE CARE UNIT	11,486	50,288	11,486	5,234	2,644	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	109	0	109	0	635	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	23,550	81,950	23,550	0	3,232	50.00
51.00	05100	RECOVERY ROOM	2,300	21,729	2,300	0	1,658	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	15,204	0	15,204	0	1,398	52.00
53.00	05300	ANESTHESIOLOGY	368	0	368	0	109	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	22,549	52,150	22,549	0	2,455	54.00
54.01	05401	ULTRASOUND	692	0	692	0	359	54.01
56.00	05600	RADIOISOTOPE	1,134	0	1,134	0	316	56.00
57.00	05700	CT SCAN	1,141	0	1,141	0	800	57.00
58.00	05800	MRI	1,347	0	1,347	0	203	58.00
60.00	06000	LABORATORY	7,773	0	7,773	0	4,291	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	400	0	400	0	172	62.00
65.00	06500	RESPIRATORY THERAPY	1,149	0	1,149	0	1,305	65.00
66.00	06600	PHYSICAL THERAPY	20,038	0	20,038	0	2,134	66.00
67.00	06700	OCCUPATIONAL THERAPY	5,416	0	5,416	0	508	67.00
68.00	06800	SPEECH PATHOLOGY	3,653	0	3,653	0	866	68.00
69.00	06900	ELECTROCARDIOLOGY	21,466	22,971	21,466	0	3,167	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	266	0	266	0	56	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	7,559	1,242	7,559	0	448	76.01
76.02	03020	ACUPUNCTURE	0	0	0	0	0	76.02
76.03	03040	WOUND CARE	4,632	0	4,632	0	7	76.03
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	13,657	117,959	13,657	3,074	2,097	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	224,031	620,836	220,886	59,600	43,929	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	744	0	744	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	16,605	161	192.00
194.00	07950	OTHER NONREIMBURSABLE COSTS	0	0	0	38	130	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
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)	23,782,892	775,866	2,828,294	2,106,856	2,882,026	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	105.807550	1.249712	12.761332	27.633435	65.174717	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	8,610,130	42,978	153,169	234,349	154,070	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	38.305550	0.069226	0.691102	3.073712	3.484170	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0006 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B-1 | Date/Time Prepared: 5/31/2023 1:02 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (HOURS)	
			7.00	8.00	9.00	10.00	11.00	
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: 15-0006 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B-1 | Date/Time Prepared: 5/31/2023 1:02 pm

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NRSING)	CENTRAL SERVICES & SUPPLY (BILLABLE SUPPLIE)	PHARMACY (100% ALLOCAT)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TOTAL PATIENT DAYS)	
			13.00	14.00	15.00	16.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
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	14,696,954					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	167	12,145,991				14.00
15.00	01500	PHARMACY	0	46,893	11,919,865			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	6,771	0	802,706,549		16.00
17.00	01700	SOCIAL SERVICE	0	1,754	0	0	20,714	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,028,138	575,220	0	58,051,402	16,288	30.00
31.00	03100	INTENSIVE CARE UNIT	2,252,499	292,176	0	14,599,414	3,121	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	0	0	0	2,453,522	1,305	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,058,704	1,560,848	0	129,675,431	0	50.00
51.00	05100	RECOVERY ROOM	1,173,760	192,025	0	20,202,330	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,672,608	202,399	0	5,171,159	0	52.00
53.00	05300	ANESTHESIOLOGY	0	181,097	0	31,599,031	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	489,567	125,236	0	16,435,951	0	54.00
54.01	05401	ULTRASOUND	2,540	15,800	0	8,538,718	0	54.01
56.00	05600	RADIOISOTOPE	611	203,197	0	11,984,958	0	56.00
57.00	05700	CT SCAN	32,436	63,095	0	36,828,079	0	57.00
58.00	05800	MRI	10,982	17,940	0	12,438,313	0	58.00
60.00	06000	LABORATORY	0	1,489,770	0	89,755,213	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	416,038	0	2,006,406	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	63,426	0	11,893,476	0	65.00
66.00	06600	PHYSICAL THERAPY	0	17,090	0	15,465,135	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,236	0	7,969,116	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	3,055	0	5,169,771	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,076,615	392,484	0	52,799,858	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	836,358	0	17,957,897	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	4,962,755	0	33,197,430	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	11,919,865	163,084,390	0	73.00
74.00	07400	RENAL DIALYSIS	1,299	28,950	0	5,156,575	0	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	21,058	0	4,131,652	0	76.01
76.02	03020	ACUPUNCTURE	0	0	0	0	0	76.02
76.03	03040	WOUND CARE	0	95,320	0	2,088,077	0	76.03
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	1,870,288	327,364	0	44,053,245	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	14,670,214	12,140,355	11,919,865	802,706,549	20,714	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	26,740	5,636	0	0	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COSTS	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
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)	5,180,341	3,177,024	3,514,601	1,983,425	1,259,034	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.352477	0.261570	0.294852	0.002471	60.781790	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	137,738	309,126	212,999	59,595	42,967	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.009372	0.025451	0.017869	0.000074	2.074298	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0006 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B-1 | Date/Time Prepared: 5/31/2023 1:02 pm

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NRSING)	CENTRAL SERVICES & SUPPLY (BILLABLE SUPPLIE)	PHARMACY (100% ALLOCAT)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TOTAL PATIENT DAYS)	
			13.00	14.00	15.00	16.00	17.00	
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: 15-0006 | Period: From 01/01/2022 To 12/31/2022 | Worksheet C Part I Date/Time Prepared: 5/31/2023 1:02 pm

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		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	26,053,641		26,053,641	0	26,053,641	30.00
31.00	03100	INTENSIVE CARE UNIT	8,906,532		8,906,532	0	8,906,532	31.00
40.00	04000	SUBPROVIDER - IPF	0		0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0		0	0	0	41.00
43.00	04300	NURSERY	834,980		834,980	0	834,980	43.00
44.00	04400	SKILLED NURSING FACILITY	0		0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	11,510,347		11,510,347	0	11,510,347	50.00
51.00	05100	RECOVERY ROOM	3,802,398		3,802,398	0	3,802,398	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,404,458		4,404,458	0	4,404,458	52.00
53.00	05300	ANESTHESIOLOGY	512,457		512,457	0	512,457	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,053,995		8,053,995	0	8,053,995	54.00
54.01	05401	ULTRASOUND	821,973		821,973	0	821,973	54.01
56.00	05600	RADIOISOTOPE	1,159,164		1,159,164	0	1,159,164	56.00
57.00	05700	CT SCAN	1,512,355		1,512,355	0	1,512,355	57.00
58.00	05800	MRI	824,176		824,176	0	824,176	58.00
60.00	06000	LABORATORY	9,415,039		9,415,039	0	9,415,039	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	995,319		995,319	0	995,319	62.00
65.00	06500	RESPIRATORY THERAPY	2,252,069	0	2,252,069	0	2,252,069	65.00
66.00	06600	PHYSICAL THERAPY	6,136,761	0	6,136,761	0	6,136,761	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,916,489	0	1,916,489	0	1,916,489	67.00
68.00	06800	SPEECH PATHOLOGY	1,660,857	0	1,660,857	0	1,660,857	68.00
69.00	06900	ELECTROCARDIOLOGY	10,157,040		10,157,040	0	10,157,040	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,565,984		1,565,984	0	1,565,984	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7,772,778		7,772,778	0	7,772,778	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	19,848,765		19,848,765	0	19,848,765	73.00
74.00	07400	RENAL DIALYSIS	775,443		775,443	0	775,443	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0		0	0	0	76.00
76.01	03610	SLEEP LAB	1,683,591		1,683,591	0	1,683,591	76.01
76.02	03020	ACUPUNCTURE	0		0	0	0	76.02
76.03	03040	WOUND CARE	1,851,822		1,851,822	0	1,851,822	76.03
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0		0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0		0	0	0	90.00
91.00	09100	EMERGENCY	9,346,286		9,346,286	0	9,346,286	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,170,154		2,170,154		2,170,154	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0		0		0	102.00
200.00		Subtotal (see instructions)	145,944,873	0	145,944,873	0	145,944,873	200.00
201.00		Less Observation Beds	2,170,154		2,170,154		2,170,154	201.00
202.00		Total (see instructions)	143,774,719	0	143,774,719	0	143,774,719	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0006 | Period: From 01/01/2022 To 12/31/2022 | Worksheet C Part I Date/Time Prepared: 5/31/2023 1:02 pm

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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	54,283,637		54,283,637			30.00
31.00	03100	INTENSIVE CARE UNIT	14,599,414		14,599,414			31.00
40.00	04000	SUBPROVIDER - IPF	0		0			40.00
41.00	04100	SUBPROVIDER - IRF	0		0			41.00
43.00	04300	NURSERY	2,453,522		2,453,522			43.00
44.00	04400	SKILLED NURSING FACILITY	0		0			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	31,141,434	98,533,997	129,675,431	0.088763	0.000000	50.00
51.00	05100	RECOVERY ROOM	3,350,857	16,851,473	20,202,330	0.188216	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,888,328	1,282,831	5,171,159	0.851735	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	9,024,764	22,574,267	31,599,031	0.016217	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,864,409	13,571,542	16,435,951	0.490023	0.000000	54.00
54.01	05401	ULTRASOUND	1,422,336	7,116,382	8,538,718	0.096264	0.000000	54.01
56.00	05600	RADIOISOTOPE	960,702	11,024,256	11,984,958	0.096718	0.000000	56.00
57.00	05700	CT SCAN	10,700,584	26,127,495	36,828,079	0.041065	0.000000	57.00
58.00	05800	MRI	2,503,170	9,935,143	12,438,313	0.066261	0.000000	58.00
60.00	06000	LABORATORY	32,690,452	57,064,761	89,755,213	0.104897	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	1,682,883	323,523	2,006,406	0.496071	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	9,408,390	2,485,086	11,893,476	0.189353	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	4,516,221	10,948,914	15,465,135	0.396813	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,389,103	3,580,013	7,969,116	0.240490	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	1,784,985	3,384,786	5,169,771	0.321263	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	17,966,786	34,833,072	52,799,858	0.192369	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	8,410,967	9,546,930	17,957,897	0.087203	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	10,693,835	22,503,595	33,197,430	0.234138	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	45,765,032	117,319,358	163,084,390	0.121709	0.000000	73.00
74.00	07400	RENAL DIALYSIS	5,156,575	0	5,156,575	0.150379	0.000000	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0	0	0	0.000000	0.000000	76.00
76.01	03610	SLEEP LAB	436,765	3,694,887	4,131,652	0.407486	0.000000	76.01
76.02	03020	ACUPUNCTURE	0	0	0	0.000000	0.000000	76.02
76.03	03040	WOUND CARE	9,444	2,078,633	2,088,077	0.886855	0.000000	76.03
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0.000000	0.000000	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
91.00	09100	EMERGENCY	11,554,788	32,498,457	44,053,245	0.212159	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,043,814	2,723,951	3,767,765	0.575979	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0			102.00
200.00		Subtotal (see instructions)	292,703,197	510,003,352	802,706,549			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	292,703,197	510,003,352	802,706,549			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0006 | Period: From 01/01/2022 To 12/31/2022 | Worksheet C Part I Date/Time Prepared: 5/31/2023 1:02 pm

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		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
40.00	04000	SUBPROVIDER - IPF			40.00
41.00	04100	SUBPROVIDER - IRF			41.00
43.00	04300	NURSERY			43.00
44.00	04400	SKILLED NURSING FACILITY			44.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.088763		50.00
51.00	05100	RECOVERY ROOM	0.188216		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.851735		52.00
53.00	05300	ANESTHESIOLOGY	0.016217		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.490023		54.00
54.01	05401	ULTRASOUND	0.096264		54.01
56.00	05600	RADIOISOTOPE	0.096718		56.00
57.00	05700	CT SCAN	0.041065		57.00
58.00	05800	MRI	0.066261		58.00
60.00	06000	LABORATORY	0.104897		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.496071		62.00
65.00	06500	RESPIRATORY THERAPY	0.189353		65.00
66.00	06600	PHYSICAL THERAPY	0.396813		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.240490		67.00
68.00	06800	SPEECH PATHOLOGY	0.321263		68.00
69.00	06900	ELECTROCARDIOLOGY	0.192369		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.087203		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.234138		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.121709		73.00
74.00	07400	RENAL DIALYSIS	0.150379		74.00
76.00	03950	OTHER ANCILLARY-OTHER	0.000000		76.00
76.01	03610	SLEEP LAB	0.407486		76.01
76.02	03020	ACUPUNCTURE	0.000000		76.02
76.03	03040	WOUND CARE	0.886855		76.03
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000		77.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.212159		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.575979		92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
102.00	10200	OPIOID TREATMENT PROGRAM			102.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0006 | Period: From 01/01/2022 To 12/31/2022 | Worksheet C Part I Date/Time Prepared: 5/31/2023 1:02 pm

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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	26,053,641		26,053,641	0	26,053,641	30.00
31.00	03100	INTENSIVE CARE UNIT	8,906,532		8,906,532	0	8,906,532	31.00
40.00	04000	SUBPROVIDER - IPF	0		0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0		0	0	0	41.00
43.00	04300	NURSERY	834,980		834,980	0	834,980	43.00
44.00	04400	SKILLED NURSING FACILITY	0		0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	11,510,347		11,510,347	0	11,510,347	50.00
51.00	05100	RECOVERY ROOM	3,802,398		3,802,398	0	3,802,398	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,404,458		4,404,458	0	4,404,458	52.00
53.00	05300	ANESTHESIOLOGY	512,457		512,457	0	512,457	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,053,995		8,053,995	0	8,053,995	54.00
54.01	05401	ULTRASOUND	821,973		821,973	0	821,973	54.01
56.00	05600	RADIOISOTOPE	1,159,164		1,159,164	0	1,159,164	56.00
57.00	05700	CT SCAN	1,512,355		1,512,355	0	1,512,355	57.00
58.00	05800	MRI	824,176		824,176	0	824,176	58.00
60.00	06000	LABORATORY	9,415,039		9,415,039	0	9,415,039	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	995,319		995,319	0	995,319	62.00
65.00	06500	RESPIRATORY THERAPY	2,252,069	0	2,252,069	0	2,252,069	65.00
66.00	06600	PHYSICAL THERAPY	6,136,761	0	6,136,761	0	6,136,761	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,916,489	0	1,916,489	0	1,916,489	67.00
68.00	06800	SPEECH PATHOLOGY	1,660,857	0	1,660,857	0	1,660,857	68.00
69.00	06900	ELECTROCARDIOLOGY	10,157,040		10,157,040	0	10,157,040	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,565,984		1,565,984	0	1,565,984	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7,772,778		7,772,778	0	7,772,778	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	19,848,765		19,848,765	0	19,848,765	73.00
74.00	07400	RENAL DIALYSIS	775,443		775,443	0	775,443	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0		0	0	0	76.00
76.01	03610	SLEEP LAB	1,683,591		1,683,591	0	1,683,591	76.01
76.02	03020	ACUPUNCTURE	0		0	0	0	76.02
76.03	03040	WOUND CARE	1,851,822		1,851,822	0	1,851,822	76.03
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0		0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0		0	0	0	90.00
91.00	09100	EMERGENCY	9,346,286		9,346,286	0	9,346,286	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,170,154		2,170,154		2,170,154	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0		0		0	102.00
200.00		Subtotal (see instructions)	145,944,873	0	145,944,873	0	145,944,873	200.00
201.00		Less Observation Beds	2,170,154		2,170,154		2,170,154	201.00
202.00		Total (see instructions)	143,774,719	0	143,774,719	0	143,774,719	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0006 | Period: From 01/01/2022 To 12/31/2022 | Worksheet C Part I | Date/Time Prepared: 5/31/2023 1:02 pm

Title XIX | Hospital | PPS

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	54,283,637		54,283,637			30.00
31.00	03100	INTENSIVE CARE UNIT	14,599,414		14,599,414			31.00
40.00	04000	SUBPROVIDER - IPF	0		0			40.00
41.00	04100	SUBPROVIDER - IRF	0		0			41.00
43.00	04300	NURSERY	2,453,522		2,453,522			43.00
44.00	04400	SKILLED NURSING FACILITY	0		0			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	31,141,434	98,533,997	129,675,431	0.088763	0.000000	50.00
51.00	05100	RECOVERY ROOM	3,350,857	16,851,473	20,202,330	0.188216	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,888,328	1,282,831	5,171,159	0.851735	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	9,024,764	22,574,267	31,599,031	0.016217	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,864,409	13,571,542	16,435,951	0.490023	0.000000	54.00
54.01	05401	ULTRASOUND	1,422,336	7,116,382	8,538,718	0.096264	0.000000	54.01
56.00	05600	RADIOISOTOPE	960,702	11,024,256	11,984,958	0.096718	0.000000	56.00
57.00	05700	CT SCAN	10,700,584	26,127,495	36,828,079	0.041065	0.000000	57.00
58.00	05800	MRI	2,503,170	9,935,143	12,438,313	0.066261	0.000000	58.00
60.00	06000	LABORATORY	32,690,452	57,064,761	89,755,213	0.104897	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	1,682,883	323,523	2,006,406	0.496071	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	9,408,390	2,485,086	11,893,476	0.189353	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	4,516,221	10,948,914	15,465,135	0.396813	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,389,103	3,580,013	7,969,116	0.240490	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	1,784,985	3,384,786	5,169,771	0.321263	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	17,966,786	34,833,072	52,799,858	0.192369	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	8,410,967	9,546,930	17,957,897	0.087203	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	10,693,835	22,503,595	33,197,430	0.234138	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	45,765,032	117,319,358	163,084,390	0.121709	0.000000	73.00
74.00	07400	RENAL DIALYSIS	5,156,575	0	5,156,575	0.150379	0.000000	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0	0	0	0.000000	0.000000	76.00
76.01	03610	SLEEP LAB	436,765	3,694,887	4,131,652	0.407486	0.000000	76.01
76.02	03020	ACUPUNCTURE	0	0	0	0.000000	0.000000	76.02
76.03	03040	WOUND CARE	9,444	2,078,633	2,088,077	0.886855	0.000000	76.03
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0.000000	0.000000	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
91.00	09100	EMERGENCY	11,554,788	32,498,457	44,053,245	0.212159	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,043,814	2,723,951	3,767,765	0.575979	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0			102.00
200.00		Subtotal (see instructions)	292,703,197	510,003,352	802,706,549			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	292,703,197	510,003,352	802,706,549			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0006 | Period: From 01/01/2022 To 12/31/2022 | Worksheet C Part I Date/Time Prepared: 5/31/2023 1:02 pm

Title XIX | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
40.00	04000	SUBPROVIDER - IPF			40.00
41.00	04100	SUBPROVIDER - IRF			41.00
43.00	04300	NURSERY			43.00
44.00	04400	SKILLED NURSING FACILITY			44.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.088763		50.00
51.00	05100	RECOVERY ROOM	0.188216		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.851735		52.00
53.00	05300	ANESTHESIOLOGY	0.016217		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.490023		54.00
54.01	05401	ULTRASOUND	0.096264		54.01
56.00	05600	RADIOISOTOPE	0.096718		56.00
57.00	05700	CT SCAN	0.041065		57.00
58.00	05800	MRI	0.066261		58.00
60.00	06000	LABORATORY	0.104897		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.496071		62.00
65.00	06500	RESPIRATORY THERAPY	0.189353		65.00
66.00	06600	PHYSICAL THERAPY	0.396813		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.240490		67.00
68.00	06800	SPEECH PATHOLOGY	0.321263		68.00
69.00	06900	ELECTROCARDIOLOGY	0.192369		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.087203		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.234138		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.121709		73.00
74.00	07400	RENAL DIALYSIS	0.150379		74.00
76.00	03950	OTHER ANCILLARY-OTHER	0.000000		76.00
76.01	03610	SLEEP LAB	0.407486		76.01
76.02	03020	ACUPUNCTURE	0.000000		76.02
76.03	03040	WOUND CARE	0.886855		76.03
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000		77.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.212159		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.575979		92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
102.00	10200	OPIOID TREATMENT PROGRAM			102.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

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

Provider CCN: 15-0006 | Period: From 01/01/2022 To 12/31/2022 | Worksheet C Part II Date/Time Prepared: 5/31/2023 1:02 pm

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	11,510,347	1,498,745	10,011,602	0	0	50.00
51.00	05100	RECOVERY ROOM	3,802,398	172,842	3,629,556	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,404,458	933,129	3,471,329	0	0	52.00
53.00	05300	ANESTHESIOLOGY	512,457	30,403	482,054	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,053,995	1,375,359	6,678,636	0	0	54.00
54.01	05401	ULTRASOUND	821,973	46,181	775,792	0	0	54.01
56.00	05600	RADIOISOTOPE	1,159,164	78,014	1,081,150	0	0	56.00
57.00	05700	CT SCAN	1,512,355	80,007	1,432,348	0	0	57.00
58.00	05800	MRI	824,176	84,329	739,847	0	0	58.00
60.00	06000	LABORATORY	9,415,039	549,897	8,865,142	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	995,319	38,215	957,104	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	2,252,069	83,395	2,168,674	0	0	65.00
66.00	06600	PHYSICAL THERAPY	6,136,761	1,209,326	4,927,435	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,916,489	327,928	1,588,561	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,660,857	224,406	1,436,451	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	10,157,040	1,334,376	8,822,664	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,565,984	27,507	1,538,477	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7,772,778	152,765	7,620,013	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	19,848,765	285,076	19,563,689	0	0	73.00
74.00	07400	RENAL DIALYSIS	775,443	19,817	755,626	0	0	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	1,683,591	452,669	1,230,922	0	0	76.01
76.02	03020	ACUPUNCTURE	0	0	0	0	0	76.02
76.03	03040	WOUND CARE	1,851,822	281,386	1,570,436	0	0	76.03
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	9,346,286	888,291	8,457,995	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,170,154	214,157	1,955,997	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
200.00		Subtotal (sum of lines 50 thru 199)	110,149,720	10,388,220	99,761,500	0	0	200.00
201.00		Less Observation Beds	2,170,154	214,157	1,955,997	0	0	201.00
202.00		Total (line 200 minus line 201)	107,979,566	10,174,063	97,805,503	0	0	202.00

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

Provider CCN: 15-0006 | Period: From 01/01/2022 To 12/31/2022 | Worksheet C Part II Date/Time Prepared: 5/31/2023 1:02 pm

Title XIX | Hospital | PPS

		Cost Center Description	Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)		
			6.00	7.00	8.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	11,510,347	129,675,431	0.088763		50.00
51.00	05100	RECOVERY ROOM	3,802,398	20,202,330	0.188216		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,404,458	5,171,159	0.851735		52.00
53.00	05300	ANESTHESIOLOGY	512,457	31,599,031	0.016217		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,053,995	16,435,951	0.490023		54.00
54.01	05401	ULTRASOUND	821,973	8,538,718	0.096264		54.01
56.00	05600	RADIOISOTOPE	1,159,164	11,984,958	0.096718		56.00
57.00	05700	CT SCAN	1,512,355	36,828,079	0.041065		57.00
58.00	05800	MRI	824,176	12,438,313	0.066261		58.00
60.00	06000	LABORATORY	9,415,039	89,755,213	0.104897		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	995,319	2,006,406	0.496071		62.00
65.00	06500	RESPIRATORY THERAPY	2,252,069	11,893,476	0.189353		65.00
66.00	06600	PHYSICAL THERAPY	6,136,761	15,465,135	0.396813		66.00
67.00	06700	OCCUPATIONAL THERAPY	1,916,489	7,969,116	0.240490		67.00
68.00	06800	SPEECH PATHOLOGY	1,660,857	5,169,771	0.321263		68.00
69.00	06900	ELECTROCARDIOLOGY	10,157,040	52,799,858	0.192369		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,565,984	17,957,897	0.087203		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7,772,778	33,197,430	0.234138		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	19,848,765	163,084,390	0.121709		73.00
74.00	07400	RENAL DIALYSIS	775,443	5,156,575	0.150379		74.00
76.00	03950	OTHER ANCILLARY-OTHER	0	0	0.000000		76.00
76.01	03610	SLEEP LAB	1,683,591	4,131,652	0.407486		76.01
76.02	03020	ACUPUNCTURE	0	0	0.000000		76.02
76.03	03040	WOUND CARE	1,851,822	2,088,077	0.886855		76.03
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0.000000		77.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	0.000000		90.00
91.00	09100	EMERGENCY	9,346,286	44,053,245	0.212159		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,170,154	3,767,765	0.575979		92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	0	0.000000		95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0.000000		102.00
200.00		Subtotal (sum of lines 50 thru 199)	110,149,720	731,369,976			200.00
201.00		Less Observation Beds	2,170,154	0			201.00
202.00		Total (line 200 minus line 201)	107,979,566	731,369,976			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-0006 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part I Date/Time Prepared: 5/31/2023 1:02 pm

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	2,571,040	0	2,571,040	17,768	144.70	30.00
31.00	INTENSIVE CARE UNIT	769,366		769,366	3,121	246.51	31.00
40.00	SUBPROVIDER - IPF	0	0	0	0	0.00	40.00
41.00	SUBPROVIDER - IRF	0	0	0	0	0.00	41.00
43.00	NURSERY	14,483		14,483	1,305	11.10	43.00
44.00	SKILLED NURSING FACILITY	0		0	0	0.00	44.00
200.00	Total (lines 30 through 199)	3,354,889		3,354,889	22,194		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	5,740	830,578	30.00
31.00	INTENSIVE CARE UNIT	1,075	264,998	31.00
40.00	SUBPROVIDER - IPF	0	0	40.00
41.00	SUBPROVIDER - IRF	0	0	41.00
43.00	NURSERY	0	0	43.00
44.00	SKILLED NURSING FACILITY	0	0	44.00
200.00	Total (lines 30 through 199)	6,815	1,095,576	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-0006 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part II Date/Time Prepared: 5/31/2023 1:02 pm

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		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,498,745	129,675,431	0.011558	9,637,352	111,389	50.00
51.00	05100	RECOVERY ROOM	172,842	20,202,330	0.008556	1,073,671	9,186	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	933,129	5,171,159	0.180449	20,492	3,698	52.00
53.00	05300	ANESTHESIOLOGY	30,403	31,599,031	0.000962	2,696,328	2,594	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,375,359	16,435,951	0.083680	1,183,376	99,025	54.00
54.01	05401	ULTRASOUND	46,181	8,538,718	0.005408	433,377	2,344	54.01
56.00	05600	RADIOISOTOPE	78,014	11,984,958	0.006509	323,936	2,108	56.00
57.00	05700	CT SCAN	80,007	36,828,079	0.002172	3,814,243	8,285	57.00
58.00	05800	MRI	84,329	12,438,313	0.006780	742,980	5,037	58.00
60.00	06000	LABORATORY	549,897	89,755,213	0.006127	10,848,650	66,470	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	38,215	2,006,406	0.019046	623,830	11,881	62.00
65.00	06500	RESPIRATORY THERAPY	83,395	11,893,476	0.007012	3,501,692	24,554	65.00
66.00	06600	PHYSICAL THERAPY	1,209,326	15,465,135	0.078197	1,837,560	143,692	66.00
67.00	06700	OCCUPATIONAL THERAPY	327,928	7,969,116	0.041150	1,794,154	73,829	67.00
68.00	06800	SPEECH PATHOLOGY	224,406	5,169,771	0.043407	721,053	31,299	68.00
69.00	06900	ELECTROCARDIOLOGY	1,334,376	52,799,858	0.025272	6,220,678	157,209	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	27,507	17,957,897	0.001532	2,424,211	3,714	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	152,765	33,197,430	0.004602	4,125,445	18,985	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	285,076	163,084,390	0.001748	16,243,412	28,393	73.00
74.00	07400	RENAL DIALYSIS	19,817	5,156,575	0.003843	2,405,661	9,245	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0	0	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	452,669	4,131,652	0.109561	112,501	12,326	76.01
76.02	03020	ACUPUNCTURE	0	0	0.000000	0	0	76.02
76.03	03040	WOUND CARE	281,386	2,088,077	0.134758	5,854	789	76.03
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0.000000	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
91.00	09100	EMERGENCY	888,291	44,053,245	0.020164	4,008,841	80,834	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	214,157	3,767,765	0.056839	361,602	20,553	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	10,388,220	731,369,976		75,160,899	927,439	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0006 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part III Date/Time Prepared: 5/31/2023 1:02 pm

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		Cost Center Description	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0		44.00
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	17,768	0.00	5,740	30.00
31.00	03100	INTENSIVE CARE UNIT		0	3,121	0.00	1,075	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0.00	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0.00	0	41.00
43.00	04300	NURSERY		0	1,305	0.00	0	43.00
44.00	04400	SKILLED NURSING FACILITY		0	0	0.00	0	44.00
200.00		Total (lines 30 through 199)		0	22,194		6,815	200.00

		Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
			9.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	41.00
43.00	04300	NURSERY	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	44.00
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0006 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part IV Date/Time Prepared: 5/31/2023 1:02 pm

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		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.02	03020	ACUPUNCTURE	0	0	0	0	0	76.02
76.03	03040	WOUND CARE	0	0	0	0	0	76.03
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0006 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part IV Date/Time Prepared: 5/31/2023 1:02 pm

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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	129,675,431	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	20,202,330	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	5,171,159	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	31,599,031	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	16,435,951	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	8,538,718	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	11,984,958	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	36,828,079	0.000000	57.00
58.00	05800	MRI	0	0	0	12,438,313	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	89,755,213	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	2,006,406	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	11,893,476	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	15,465,135	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	7,969,116	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	5,169,771	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	52,799,858	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	17,957,897	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	33,197,430	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	163,084,390	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	5,156,575	0.000000	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0	0	0	0	0.000000	76.00
76.01	03610	SLEEP LAB	0	0	0	4,131,652	0.000000	76.01
76.02	03020	ACUPUNCTURE	0	0	0	0	0.000000	76.02
76.03	03040	WOUND CARE	0	0	0	2,088,077	0.000000	76.03
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0.000000	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	44,053,245	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	3,767,765	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	731,369,976		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0006 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part IV Date/Time Prepared: 5/31/2023 1:02 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	9,637,352	0	23,978,955	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	1,073,671	0	3,368,357	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	20,492	0	185,432	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	2,696,328	0	4,909,364	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	1,183,376	0	3,009,344	0	54.00
54.01	05401	ULTRASOUND	0.000000	433,377	0	815,448	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	323,936	0	3,861,601	0	56.00
57.00	05700	CT SCAN	0.000000	3,814,243	0	5,888,026	0	57.00
58.00	05800	MRI	0.000000	742,980	0	2,546,555	0	58.00
60.00	06000	LABORATORY	0.000000	10,848,650	0	5,367,147	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	623,830	0	114,642	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.000000	3,501,692	0	867,184	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	1,837,560	0	27,311	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	1,794,154	0	18,990	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	721,053	0	18,195	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	6,220,678	0	12,299,844	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	2,424,211	0	1,626,251	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	4,125,445	0	7,475,041	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	16,243,412	0	38,273,498	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	2,405,661	0	0	0	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0.000000	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0.000000	112,501	0	616,203	0	76.01
76.02	03020	ACUPUNCTURE	0.000000	0	0	0	0	76.02
76.03	03040	WOUND CARE	0.000000	5,854	0	803,669	0	76.03
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	4,008,841	0	4,737,769	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	361,602	0	547,517	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		75,160,899	0	121,356,343	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0006 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part V Date/Time Prepared: 5/31/2023 1:02 pm

Title XVIII | Hospital | PPS

		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	0.088763	23,978,955	0	0	2,128,444	50.00
51.00	05100	RECOVERY ROOM	0.188216	3,368,357	0	0	633,979	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.851735	185,432	0	0	157,939	52.00
53.00	05300	ANESTHESIOLOGY	0.016217	4,909,364	0	0	79,615	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.490023	3,009,344	0	0	1,474,648	54.00
54.01	05401	ULTRASOUND	0.096264	815,448	0	0	78,498	54.01
56.00	05600	RADIOISOTOPE	0.096718	3,861,601	0	0	373,486	56.00
57.00	05700	CT SCAN	0.041065	5,888,026	0	0	241,792	57.00
58.00	05800	MRI	0.066261	2,546,555	0	0	168,737	58.00
60.00	06000	LABORATORY	0.104897	5,367,147	912	0	562,998	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.496071	114,642	0	0	56,871	62.00
65.00	06500	RESPIRATORY THERAPY	0.189353	867,184	0	0	164,204	65.00
66.00	06600	PHYSICAL THERAPY	0.396813	27,311	0	0	10,837	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.240490	18,990	0	0	4,567	67.00
68.00	06800	SPEECH PATHOLOGY	0.321263	18,195	0	0	5,845	68.00
69.00	06900	ELECTROCARDIOLOGY	0.192369	12,299,844	0	0	2,366,109	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.087203	1,626,251	0	0	141,814	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.234138	7,475,041	0	0	1,750,191	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.121709	38,273,498	0	33,606	4,658,229	73.00
74.00	07400	RENAL DIALYSIS	0.150379	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0.000000	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0.407486	616,203	0	0	251,094	76.01
76.02	03020	ACUPUNCTURE	0.000000	0	0	0	0	76.02
76.03	03040	WOUND CARE	0.886855	803,669	0	0	712,738	76.03
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.212159	4,737,769	0	0	1,005,160	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.575979	547,517	0	0	315,358	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000		0			95.00
200.00		Subtotal (see instructions)		121,356,343	912	33,606	17,343,153	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		121,356,343	912	33,606	17,343,153	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0006 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part V Date/Time Prepared: 5/31/2023 1:02 pm

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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
51.00	05100	RECOVERY ROOM	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
54.01	05401	ULTRASOUND	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	56.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MRI	0	0	58.00
60.00	06000	LABORATORY	96	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	62.00
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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	4,090	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0	0	76.00
76.01	03610	SLEEP LAB	0	0	76.01
76.02	03020	ACUPUNCTURE	0	0	76.02
76.03	03040	WOUND CARE	0	0	76.03
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0		95.00
200.00		Subtotal (see instructions)	96	4,090	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	96	4,090	202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-0006 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part I Date/Time Prepared: 5/31/2023 1:02 pm

Title XIX | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	2,571,040	0	2,571,040	17,768	144.70	30.00
31.00	INTENSIVE CARE UNIT	769,366		769,366	3,121	246.51	31.00
40.00	SUBPROVIDER - IPF	0	0	0	0	0.00	40.00
41.00	SUBPROVIDER - IRF	0	0	0	0	0.00	41.00
43.00	NURSERY	14,483		14,483	1,305	11.10	43.00
44.00	SKILLED NURSING FACILITY	0		0	0	0.00	44.00
200.00	Total (lines 30 through 199)	3,354,889		3,354,889	22,194		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	687	99,409	30.00
31.00	INTENSIVE CARE UNIT	39	9,614	31.00
40.00	SUBPROVIDER - IPF	0	0	40.00
41.00	SUBPROVIDER - IRF	0	0	41.00
43.00	NURSERY	961	10,667	43.00
44.00	SKILLED NURSING FACILITY	0	0	44.00
200.00	Total (lines 30 through 199)	1,687	119,690	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-0006 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part II Date/Time Prepared: 5/31/2023 1:02 pm

Title XIX | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,498,745	129,675,431	0.011558	663,001	7,663	50.00
51.00	05100	RECOVERY ROOM	172,842	20,202,330	0.008556	85,333	730	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	933,129	5,171,159	0.180449	121,135	21,859	52.00
53.00	05300	ANESTHESIOLOGY	30,403	31,599,031	0.000962	174,449	168	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,375,359	16,435,951	0.083680	90,844	7,602	54.00
54.01	05401	ULTRASOUND	46,181	8,538,718	0.005408	58,439	316	54.01
56.00	05600	RADIOISOTOPE	78,014	11,984,958	0.006509	21,143	138	56.00
57.00	05700	CT SCAN	80,007	36,828,079	0.002172	362,979	788	57.00
58.00	05800	MRI	84,329	12,438,313	0.006780	89,293	605	58.00
60.00	06000	LABORATORY	549,897	89,755,213	0.006127	1,245,353	7,630	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	38,215	2,006,406	0.019046	48,118	916	62.00
65.00	06500	RESPIRATORY THERAPY	83,395	11,893,476	0.007012	337,845	2,369	65.00
66.00	06600	PHYSICAL THERAPY	1,209,326	15,465,135	0.078197	157,136	12,288	66.00
67.00	06700	OCCUPATIONAL THERAPY	327,928	7,969,116	0.041150	148,026	6,091	67.00
68.00	06800	SPEECH PATHOLOGY	224,406	5,169,771	0.043407	85,334	3,704	68.00
69.00	06900	ELECTROCARDIOLOGY	1,334,376	52,799,858	0.025272	356,428	9,008	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	27,507	17,957,897	0.001532	129,276	198	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	152,765	33,197,430	0.004602	131,065	603	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	285,076	163,084,390	0.001748	1,569,749	2,744	73.00
74.00	07400	RENAL DIALYSIS	19,817	5,156,575	0.003843	232,691	894	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0	0	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	452,669	4,131,652	0.109561	13,348	1,462	76.01
76.02	03020	ACUPUNCTURE	0	0	0.000000	0	0	76.02
76.03	03040	WOUND CARE	281,386	2,088,077	0.134758	3,590	484	76.03
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0.000000	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
91.00	09100	EMERGENCY	888,291	44,053,245	0.020164	403,128	8,129	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	214,157	3,767,765	0.056839	25,044	1,423	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	10,388,220	731,369,976		6,552,747	97,812	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0006 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part III Date/Time Prepared: 5/31/2023 1:02 pm

Title XIX | Hospital | PPS

		Cost Center Description	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0		44.00
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	17,768	0.00	687	30.00
31.00	03100	INTENSIVE CARE UNIT		0	3,121	0.00	39	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0.00	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0.00	0	41.00
43.00	04300	NURSERY		0	1,305	0.00	961	43.00
44.00	04400	SKILLED NURSING FACILITY		0	0	0.00	0	44.00
200.00		Total (lines 30 through 199)		0	22,194		1,687	200.00

		Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
			9.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	41.00
43.00	04300	NURSERY	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	44.00
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0006 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part IV | Date/Time Prepared: 5/31/2023 1:02 pm

Title XIX | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.02	03020	ACUPUNCTURE	0	0	0	0	0	76.02
76.03	03040	WOUND CARE	0	0	0	0	0	76.03
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0006 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part IV Date/Time Prepared: 5/31/2023 1:02 pm

Title XIX | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	129,675,431	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	20,202,330	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	5,171,159	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	31,599,031	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	16,435,951	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	8,538,718	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	11,984,958	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	36,828,079	0.000000	57.00
58.00	05800	MRI	0	0	0	12,438,313	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	89,755,213	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	2,006,406	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	11,893,476	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	15,465,135	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	7,969,116	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	5,169,771	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	52,799,858	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	17,957,897	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	33,197,430	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	163,084,390	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	5,156,575	0.000000	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0	0	0	0	0.000000	76.00
76.01	03610	SLEEP LAB	0	0	0	4,131,652	0.000000	76.01
76.02	03020	ACUPUNCTURE	0	0	0	0	0.000000	76.02
76.03	03040	WOUND CARE	0	0	0	2,088,077	0.000000	76.03
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0.000000	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	44,053,245	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	3,767,765	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	731,369,976		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0006 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part IV | Date/Time Prepared: 5/31/2023 1:02 pm

Title XIX | Hospital | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	663,001	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	85,333	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	121,135	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	174,449	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	90,844	0	0	0	54.00
54.01	05401	ULTRASOUND	0.000000	58,439	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	21,143	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	362,979	0	0	0	57.00
58.00	05800	MRI	0.000000	89,293	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	1,245,353	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	48,118	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.000000	337,845	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	157,136	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	148,026	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	85,334	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	356,428	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	129,276	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	131,065	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	1,569,749	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	232,691	0	0	0	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0.000000	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0.000000	13,348	0	0	0	76.01
76.02	03020	ACUPUNCTURE	0.000000	0	0	0	0	76.02
76.03	03040	WOUND CARE	0.000000	3,590	0	0	0	76.03
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	403,128	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	25,044	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		6,552,747	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0006 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part V Date/Time Prepared: 5/31/2023 1:02 pm

Title XIX | Hospital | PPS

		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	0.088763	0	0	883,451	0	50.00
51.00	05100	RECOVERY ROOM	0.188216	0	0	144,673	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.851735	0	0	21,523	0	52.00
53.00	05300	ANESTHESIOLOGY	0.016217	0	0	200,740	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.490023	0	0	166,967	0	54.00
54.01	05401	ULTRASOUND	0.096264	0	0	106,317	0	54.01
56.00	05600	RADIOISOTOPE	0.096718	0	0	89,913	0	56.00
57.00	05700	CT SCAN	0.041065	0	0	570,233	0	57.00
58.00	05800	MRI	0.066261	0	0	134,371	0	58.00
60.00	06000	LABORATORY	0.104897	0	0	1,005,034	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.496071	0	0	9,365	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.189353	0	0	9,830	0	65.00
66.00	06600	PHYSICAL THERAPY	0.396813	0	0	31,984	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.240490	0	0	32,400	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.321263	0	0	45,644	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.192369	0	0	204,196	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.087203	0	0	149,926	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.234138	0	0	178,153	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.121709	0	0	301,780	0	73.00
74.00	07400	RENAL DIALYSIS	0.150379	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0.000000	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0.407486	0	0	46,904	0	76.01
76.02	03020	ACUPUNCTURE	0.000000	0	0	0	0	76.02
76.03	03040	WOUND CARE	0.886855	0	0	43,323	0	76.03
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.212159	0	0	1,089,044	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.575979	0	0	57,087	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000	0	0			95.00
200.00		Subtotal (see instructions)		0	0	5,522,858	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	0	5,522,858	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0006 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part V Date/Time Prepared: 5/31/2023 1:02 pm

Title XIX | Hospital | PPS

		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	78,418		50.00
51.00	05100	RECOVERY ROOM	0	27,230		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	18,332		52.00
53.00	05300	ANESTHESIOLOGY	0	3,255		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	81,818		54.00
54.01	05401	ULTRASOUND	0	10,234		54.01
56.00	05600	RADIOISOTOPE	0	8,696		56.00
57.00	05700	CT SCAN	0	23,417		57.00
58.00	05800	MRI	0	8,904		58.00
60.00	06000	LABORATORY	0	105,425		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	4,646		62.00
65.00	06500	RESPIRATORY THERAPY	0	1,861		65.00
66.00	06600	PHYSICAL THERAPY	0	12,692		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	7,792		67.00
68.00	06800	SPEECH PATHOLOGY	0	14,664		68.00
69.00	06900	ELECTROCARDIOLOGY	0	39,281		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	13,074		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	41,712		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	36,729		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03950	OTHER ANCILLARY-OTHER	0	0		76.00
76.01	03610	SLEEP LAB	0	19,113		76.01
76.02	03020	ACUPUNCTURE	0	0		76.02
76.03	03040	WOUND CARE	0	38,421		76.03
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0		77.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	231,050		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	32,881		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	0	859,645		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	859,645		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0006 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-1 | Date/Time Prepared: 5/31/2023 1:02 pm

Title XVIII | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	17,892	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	17,768	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)	16,288	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	124	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)	5,740	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)	92	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)	26,053,641	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)	26,053,641	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)	26,053,641	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)	1,466.32	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	8,416,677	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)	8,416,677	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0006 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-1 | Date/Time Prepared: 5/31/2023 1:02 pm

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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	8,906,532	3,121	2,853.74	1,075	3,067,771	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	11,302,837	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)	22,787,285	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	1,095,576	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	927,439	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	2,023,015	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	20,764,270	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
55.01	Permanent adjustment amount per discharge	0.00	55.01
55.02	Adjustment amount per discharge (contractor use only)	0.00	55.02
56.00	Target amount (line 54 x sum of lines 55, 55.01, and 55.02)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)	0.00	59.00
60.00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)	0.00	60.00
61.00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	1,480	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,466.32	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	2,170,154	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0006 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-1 | Date/Time Prepared: 5/31/2023 1:02 pm

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	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	2,571,040	26,053,641	0.098683	2,170,154	214,157	90.00
91.00	Nursing Program cost	0	26,053,641	0.000000	2,170,154	0	91.00
92.00	Allied health cost	0	26,053,641	0.000000	2,170,154	0	92.00
93.00	All other Medical Education	0	26,053,641	0.000000	2,170,154	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0006 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-1 | Date/Time Prepared: 5/31/2023 1:02 pm

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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)	17,892	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	17,768	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)	16,288	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	124	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)	687	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)	1,305	15.00
16.00	Nursery days (title V or XIX only)	961	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)	26,053,641	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)	26,053,641	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)	26,053,641	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)	1,466.32	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,007,362	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	1,007,362	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0006 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-1 | Date/Time Prepared: 5/31/2023 1:02 pm

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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)	834,980	1,305	639.83	961	614,877	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	8,906,532	3,121	2,853.74	39	111,296	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	1,042,915	48.00
48.01	Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)	0	48.01
49.00	Total Program inpatient costs (sum of lines 41 through 48.01)(see instructions)	2,776,450	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)	119,690	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	97,812	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	217,502	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	2,558,948	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
55.01	Permanent adjustment amount per discharge	0.00	55.01
55.02	Adjustment amount per discharge (contractor use only)	0.00	55.02
56.00	Target amount (line 54 x sum of lines 55, 55.01, and 55.02)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)	0.00	59.00
60.00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)	0.00	60.00
61.00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	1,480	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,466.32	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	2,170,154	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0006 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-1 | Date/Time Prepared: 5/31/2023 1:02 pm

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	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	2,571,040	26,053,641	0.098683	2,170,154	214,157	90.00
91.00	Nursing Program cost	0	26,053,641	0.000000	2,170,154	0	91.00
92.00	Allied health cost	0	26,053,641	0.000000	2,170,154	0	92.00
93.00	All other Medical Education	0	26,053,641	0.000000	2,170,154	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0006 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-3 | Date/Time Prepared: 5/31/2023 1:02 pm

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		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		18,298,300		30.00
31.00	03100	INTENSIVE CARE UNIT		4,928,019		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.088763	9,637,352	855,440	50.00
51.00	05100	RECOVERY ROOM	0.188216	1,073,671	202,082	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.851735	20,492	17,454	52.00
53.00	05300	ANESTHESIOLOGY	0.016217	2,696,328	43,726	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.490023	1,183,376	579,881	54.00
54.01	05401	ULTRASOUND	0.096264	433,377	41,719	54.01
56.00	05600	RADIOISOTOPE	0.096718	323,936	31,330	56.00
57.00	05700	CT SCAN	0.041065	3,814,243	156,632	57.00
58.00	05800	MRI	0.066261	742,980	49,231	58.00
60.00	06000	LABORATORY	0.104897	10,848,650	1,137,991	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.496071	623,830	309,464	62.00
65.00	06500	RESPIRATORY THERAPY	0.189353	3,501,692	663,056	65.00
66.00	06600	PHYSICAL THERAPY	0.396813	1,837,560	729,168	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.240490	1,794,154	431,476	67.00
68.00	06800	SPEECH PATHOLOGY	0.321263	721,053	231,648	68.00
69.00	06900	ELECTROCARDIOLOGY	0.192369	6,220,678	1,196,666	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.087203	2,424,211	211,398	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.234138	4,125,445	965,923	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.121709	16,243,412	1,976,969	73.00
74.00	07400	RENAL DIALYSIS	0.150379	2,405,661	361,761	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	0.407486	112,501	45,843	76.01
76.02	03020	ACUPUNCTURE	0.000000	0	0	76.02
76.03	03040	WOUND CARE	0.886855	5,854	5,192	76.03
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
91.00	09100	EMERGENCY	0.212159	4,008,841	850,512	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.575979	361,602	208,275	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		75,160,899	11,302,837	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)		75,160,899		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-0006 | Component CCN: 15-U006 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-3 | Date/Time Prepared: 5/31/2023 1:02 pm

Title XVIII | Swing Beds - SNF | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
40.00	04000	SUBPROVIDER - IPF				40.00
41.00	04100	SUBPROVIDER - IRF				41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.088763	0	0	50.00
51.00	05100	RECOVERY ROOM	0.188216	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.851735	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.016217	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.490023	2,952	1,447	54.00
54.01	05401	ULTRASOUND	0.096264	0	0	54.01
56.00	05600	RADIOISOTOPE	0.096718	0	0	56.00
57.00	05700	CT SCAN	0.041065	0	0	57.00
58.00	05800	MRI	0.066261	0	0	58.00
60.00	06000	LABORATORY	0.104897	26,282	2,757	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.496071	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.189353	2,453	464	65.00
66.00	06600	PHYSICAL THERAPY	0.396813	37,466	14,867	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.240490	38,342	9,221	67.00
68.00	06800	SPEECH PATHOLOGY	0.321263	7,642	2,455	68.00
69.00	06900	ELECTROCARDIOLOGY	0.192369	529	102	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.087203	3,000	262	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.234138	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.121709	23,959	2,916	73.00
74.00	07400	RENAL DIALYSIS	0.150379	0	0	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	0.407486	0	0	76.01
76.02	03020	ACUPUNCTURE	0.000000	0	0	76.02
76.03	03040	WOUND CARE	0.886855	0	0	76.03
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
91.00	09100	EMERGENCY	0.212159	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.575979	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		142,625	34,491	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)		142,625		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0006 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-3 | Date/Time Prepared: 5/31/2023 1:02 pm

Title XIX | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		1,970,414		30.00
31.00	03100	INTENSIVE CARE UNIT		597,859		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
43.00	04300	NURSERY		110,757		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.088763	663,001	58,850	50.00
51.00	05100	RECOVERY ROOM	0.188216	85,333	16,061	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.851735	121,135	103,175	52.00
53.00	05300	ANESTHESIOLOGY	0.016217	174,449	2,829	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.490023	90,844	44,516	54.00
54.01	05401	ULTRASOUND	0.096264	58,439	5,626	54.01
56.00	05600	RADIOISOTOPE	0.096718	21,143	2,045	56.00
57.00	05700	CT SCAN	0.041065	362,979	14,906	57.00
58.00	05800	MRI	0.066261	89,293	5,917	58.00
60.00	06000	LABORATORY	0.104897	1,245,353	130,634	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.496071	48,118	23,870	62.00
65.00	06500	RESPIRATORY THERAPY	0.189353	337,845	63,972	65.00
66.00	06600	PHYSICAL THERAPY	0.396813	157,136	62,354	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.240490	148,026	35,599	67.00
68.00	06800	SPEECH PATHOLOGY	0.321263	85,334	27,415	68.00
69.00	06900	ELECTROCARDIOLOGY	0.192369	356,428	68,566	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.087203	129,276	11,273	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.234138	131,065	30,687	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.121709	1,569,749	191,053	73.00
74.00	07400	RENAL DIALYSIS	0.150379	232,691	34,992	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	0.407486	13,348	5,439	76.01
76.02	03020	ACUPUNCTURE	0.000000	0	0	76.02
76.03	03040	WOUND CARE	0.886855	3,590	3,184	76.03
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
91.00	09100	EMERGENCY	0.212159	403,128	85,527	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.575979	25,044	14,425	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		6,552,747	1,042,915	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)		6,552,747		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-0006 | Component CCN: 15-U006 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-3 | Date/Time Prepared: 5/31/2023 1:02 pm

Title XIX | Swing Beds - SNF | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
40.00	04000	SUBPROVIDER - IPF				40.00
41.00	04100	SUBPROVIDER - IRF				41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.088763	0	0	50.00
51.00	05100	RECOVERY ROOM	0.188216	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.851735	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.016217	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.490023	0	0	54.00
54.01	05401	ULTRASOUND	0.096264	0	0	54.01
56.00	05600	RADIOISOTOPE	0.096718	0	0	56.00
57.00	05700	CT SCAN	0.041065	0	0	57.00
58.00	05800	MRI	0.066261	0	0	58.00
60.00	06000	LABORATORY	0.104897	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.496071	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.189353	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.396813	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.240490	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.321263	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.192369	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.087203	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.234138	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.121709	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.150379	0	0	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	0.407486	0	0	76.01
76.02	03020	ACUPUNCTURE	0.000000	0	0	76.02
76.03	03040	WOUND CARE	0.886855	0	0	76.03
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
91.00	09100	EMERGENCY	0.212159	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.575979	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		0	0	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		0		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0006	Period: From 01/01/2022 To 12/31/2022	Worksheet E Part A Date/Time Prepared: 5/31/2023 1:02 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		
1.00	DRG Amounts Other than Outlier Payments	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	10,763,950	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	3,779,672	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)	772,021	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)	126,396	2.04
3.00	Managed Care Simulated Payments	9,127,226	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	69.61	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)	2.77	30.00
31.00	Percentage of Medicaid patient days (see instructions)	26.00	31.00
32.00	Sum of lines 30 and 31	28.77	32.00
33.00	Allowable disproportionate share percentage (see instructions)	12.95	33.00
34.00	Disproportionate share adjustment (see instructions)	470,850	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0006	Period: From 01/01/2022 To 12/31/2022	Worksheet E Part A Date/Time Prepared: 5/31/2023 1:02 pm
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		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)	756,886	685,817	35.02
35.03	Pro rata share of the hospital UCP, including supplemental UCP (see instructions)	566,109	172,864	35.03
36.00	Total UCP adjustment (sum of columns 1 and 2 on line 35.03)	738,973		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)	16,651,862		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)	16,651,862	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	1,232,814	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	128,691	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)	18,013,367	59.00
60.00	Primary payer payments	14,909	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	17,998,458	61.00
62.00	Deductibles billed to program beneficiaries	1,593,244	62.00
63.00	Coinsurance billed to program beneficiaries	87,525	63.00
64.00	Allowable bad debts (see instructions)	117,479	64.00
65.00	Adjusted reimbursable bad debts (see instructions)	76,361	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	15,493	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	16,394,050	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)	-143,212	70.94
70.95	Recovery of accelerated depreciation	0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0006	Period: From 01/01/2022 To 12/31/2022	Worksheet E Part A Date/Time Prepared: 5/31/2023 1:02 pm
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		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)		133,059	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		16,117,779	71.00
71.01	Sequestration adjustment (see instructions)		203,084	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		15,848,336	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)		66,359	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		1,678,529	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: 15-0006	Period: From 01/01/2022 To 12/31/2022	Worksheet E Part B Date/Time Prepared: 5/31/2023 1:02 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	4,186	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	17,343,153	2.00
3.00	OPPS payments	14,146,049	3.00
4.00	Outlier payment (see instructions)	33,599	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)	4,186	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	34,518	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)	34,518	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)	34,518	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	30,332	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)	4,186	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)	14,179,648	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	16,557	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	2,518,594	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)	11,648,683	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)	11,648,683	30.00
31.00	Primary payer payments	2,651	31.00
32.00	Subtotal (line 30 minus line 31)	11,646,032	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)	229,093	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	148,910	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	129,171	36.00
37.00	Subtotal (see instructions)	11,794,942	37.00
38.00	MSP-LCC reconciliation amount from PS&R	-152	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)	11,795,094	40.00
40.01	Sequestration adjustment (see instructions)	148,618	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	11,639,986	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)	6,490	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: 15-0006	Period: From 01/01/2022 To 12/31/2022	Worksheet E Part B Date/Time Prepared: 5/31/2023 1:02 pm
	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: 15-0006 | Period: From 01/01/2022 To 12/31/2022 | Worksheet E-1 Part I | Date/Time Prepared: 5/31/2023 1:02 pm

Title XVIII | Hospital | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		15,775,436		11,639,986	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	10/05/2022	72,900		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)		72,900		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)		15,848,336		11,639,986	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		66,359		6,490	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		15,914,695		11,646,476	7.00

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-0006 | Component CCN: 15-U006 | Period: From 01/01/2022 To 12/31/2022 | Worksheet E-1 Part I | Date/Time Prepared: 5/31/2023 1:02 pm

Title XVIII | Swing Beds - SNF | 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		42,666		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		42,666		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		49,862		0	6.02
7.00	Total Medicare program liability (see instructions)		-7,196		0	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-0006	Period: From 01/01/2022 To 12/31/2022	Worksheet E-1 Part II Date/Time Prepared: 5/31/2023 1:02 pm
	Title XVIII	Hospital	PPS

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

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 15-0006 | Component CCN: 15-U006 | Period: From 01/01/2022 To 12/31/2022 | Worksheet E-2 | Date/Time Prepared: 5/31/2023 1:02 pm

Title XVIII | Swing Beds - SNF | PPS

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	0	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swing-bed pass-through, see instructions)	0	0	3.00
3.01	Nursing and allied health payment-PARHM or CHART (see instructions)			3.01
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	92	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	0	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	0	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	0	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	7,196	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (see instructions)	-7,196	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			16.50
16.55	Rural community hospital demonstration project (§410A Demonstration) payment adjustment (see instructions)	0		16.55
16.99	Demonstration payment adjustment amount before sequestration	0	0	16.99
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	-7,196	0	19.00
19.01	Sequestration adjustment (see instructions)	0	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0	0	19.02
19.03	Sequestration adjustment-PARHM or CHART pass-throughs			19.03
19.25	Sequestration for non-claims based amounts (see instructions)	0	0	19.25
20.00	Interim payments	42,666	0	20.00
20.01	Interim payments-PARHM or CHART			20.01
21.00	Tentative settlement (for contractor use only)	0	0	21.00
21.01	Tentative settlement-PARHM or CHART (for contractor use only)			21.01
22.00	Balance due provider/program (line 19 minus lines 19.01, 19.02, 19.25, 20, and 21)	-49,862	0	22.00
22.01	Balance due provider/program-PARHM or CHART (see instructions)			22.01
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	23.00
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
	Cost Reimbursement			
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))			201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))			202.00
203.00	Total (sum of lines 201 and 202)			203.00
204.00	Medicare swing-bed SNF discharges (see instructions)			204.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
205.00	Medicare swing-bed SNF target amount			205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)			206.00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)			208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
	Comparision of PPS versus Cost Reimbursement			
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)			215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 15-0006 | Component CCN: 15-U006 | Period: From 01/01/2022 To 12/31/2022 | Worksheet E-2 | Date/Time Prepared: 5/31/2023 1:02 pm

Title XIX | Swing Beds - SNF | PPS

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

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0006 | Period: From 01/01/2022 To 12/31/2022 | Worksheet E-3 Part VII | Date/Time Prepared: 5/31/2023 1:02 pm

Title XIX | Hospital | PPS

		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	0		1.00
2.00	Medical and other services		859,645	2.00
3.00	Organ acquisition (certified transplant programs only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	0	859,645	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)	0	859,645	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	2,679,030		8.00
9.00	Ancillary service charges	6,552,747	5,522,858	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)	9,231,777	5,522,858	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)	9,231,777	5,522,858	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	9,231,777	4,663,213	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)	0	859,645	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)	0	859,645	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)	0	859,645	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)	0	859,645	36.00
37.00	REMOVE SETTLEMENT	0	-859,645	37.00
38.00	Subtotal (line 36 ± line 37)	0	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)	0	0	40.00
41.00	Interim payments	0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	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: 15-0006	Period: From 01/01/2022 To 12/31/2022	Worksheet E-5 Date/Time Prepared: 5/31/2023 1:02 pm
	Title XVIII		PPS

		1.00	
	TO BE COMPLETED BY CONTRACTOR		
1.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)	0	1.00
2.00	Capital outlier from Wkst. L, Pt. 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: 15-0006 | Period: From 01/01/2022 To 12/31/2022 | Worksheet G | Date/Time Prepared: 5/31/2023 1:02 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	-33,446	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	41,233,688	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-11,122,678	0	0	0	6.00
7.00	Inventory	4,137,048	0	0	0	7.00
8.00	Prepaid expenses	2,157,175	0	0	0	8.00
9.00	Other current assets	142,719	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)	36,514,506	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	3,046,255	0	0	0	12.00
13.00	Land improvements	2,290,554	0	0	0	13.00
14.00	Accumulated depreciation	-1,042,138	0	0	0	14.00
15.00	Buildings	136,086,008	0	0	0	15.00
16.00	Accumulated depreciation	-24,287,406	0	0	0	16.00
17.00	Leasehold improvements	2,566,009	0	0	0	17.00
18.00	Accumulated depreciation	-36,626	0	0	0	18.00
19.00	Fixed equipment	2,256,972	0	0	0	19.00
20.00	Accumulated depreciation	-678,863	0	0	0	20.00
21.00	Automobiles and trucks	101,790	0	0	0	21.00
22.00	Accumulated depreciation	-101,790	0	0	0	22.00
23.00	Major movable equipment	29,109,826	0	0	0	23.00
24.00	Accumulated depreciation	-13,414,226	0	0	0	24.00
25.00	Minor equipment depreciable	8,322,352	0	0	0	25.00
26.00	Accumulated depreciation	-4,029,905	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	22,154,672	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	162,343,484	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	9,133,099	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	9,133,099	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	207,991,089	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	6,147,511	0	0	0	37.00
38.00	Salaries, wages, and fees payable	5,221,189	0	0	0	38.00
39.00	Payroll taxes payable	501,225	0	0	0	39.00
40.00	Notes and loans payable (short term)	100,000	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	64,438,645	0	0	0	43.00
44.00	Other current liabilities	2,702,851	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	79,111,421	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	22,384,577	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	22,384,577	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	101,495,998	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	106,495,091				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)	106,495,091	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	207,991,089	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-0006 | Period: From 01/01/2022 To 12/31/2022 | Worksheet G-1 | Date/Time Prepared: 5/31/2023 1:02 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		63,971,065		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		42,524,026				2.00
3.00	Total (sum of line 1 and line 2)		106,495,091		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)		106,495,091		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)		106,495,091		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: 15-0006 | Period: From 01/01/2022 To 12/31/2022 | Worksheet G-2 Parts I & II | Date/Time Prepared: 5/31/2023 1:02 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	57,344,770		57,344,770	1.00
2.00	SUBPROVIDER - IPF	0		0	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	0		0	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)	57,344,770		57,344,770	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	15,595,031		15,595,031	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)	15,595,031		15,595,031	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	72,939,801		72,939,801	17.00
18.00	Ancillary services	208,711,202	474,874,349	683,585,551	18.00
19.00	Outpatient services	11,935,393	34,245,809	46,181,202	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	0	0	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	293,586,396	509,120,158	802,706,554	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		155,344,803		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)		155,344,803		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 15-0006	Period: From 01/01/2022 To 12/31/2022	Worksheet G-3 Date/Time Prepared: 5/31/2023 1:02 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	802,706,554	1.00
2.00	Less contractual allowances and discounts on patients' accounts	610,326,857	2.00
3.00	Net patient revenues (line 1 minus line 2)	192,379,697	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	155,344,803	4.00
5.00	Net income from service to patients (line 3 minus line 4)	37,034,894	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER INCOME	5,489,132	24.00
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	5,489,132	25.00
26.00	Total (line 5 plus line 25)	42,524,026	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)	42,524,026	29.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 15-0006	Period: From 01/01/2022 To 12/31/2022	Worksheet L Parts I-III Date/Time Prepared: 5/31/2023 1:02 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	1,091,414	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	141,400	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)	54.58	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)	1,232,814	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