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: 15-2014	Period: From 01/01/2022 To 12/31/2022	Worksheet S Parts I-III Date/Time Prepared: 4/28/2023 10:34 am

PART I - COST REPORT STATUS

Date: 4/28/2023 Time: 10:34 am

Provider use only

1. [X] Electronically prepared cost report
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 SSH - EVANSVILLE, LLC. (15-2014) 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	Christopher Weigl		Y	I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name	Christopher Weigl			2
3	Signatory Title	SENIOR VICE PRESIDENT			3
4	Date	04/28/2023 07:39:37 AM (PT)			4

Encryption Information
ECR: Date: 4/28/2023 Time: 10:34 am
sR:JtYyN4TuWiAviCe:Pp:YysOBcwO
jCQip01FNIgMrpgYFlwXHHN.2yOw3P
35Ki07VuoG0.OBrA

		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	761,384	0	0	0	1.00
2.00	SUBPROVIDER - IPF	0	0	0		0	2.00
3.00	SUBPROVIDER - IRF	0	0	0		0	3.00
5.00	SWING BED - SNF	0	0	0		0	5.00
6.00	SWING BED - NF	0				0	6.00
200.00	TOTAL	0	761,384	0	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: 15-2014 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-2 Part I | Date/Time Prepared: 4/28/2023 10:34 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 400 SE 4TH STREET	PO Box:			1.00
2.00	City: EVANSVILLE	State: IN	Zip Code: 47713	County: VANDERBURGH	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	SSH - EVANSVILLE, LLC.	152014	21780	2	01/01/1997	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									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.	N	N		22.00
22.01	Did this hospital receive interim UCPs, including supplemental UCPs, for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N		22.01
22.02	Is this a newly merged hospital that requires a final UCP to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or “N” for no.	N	N	N	22.03
22.04	Did this hospital receive a geographic reclassification from urban to rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.				22.04
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	3	N		23.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-2014 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-2 Part I | Date/Time Prepared: 4/28/2023 10:34 am

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

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

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

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

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? For cost reporting periods beginning prior to December 27, 2020, enter "Y" for yes or "N" for no in column 1. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.78(b)(2), see the instructions. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2.	N			56.00
57.00	For cost reporting periods beginning prior to December 27, 2020, if line 56, column 1, is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.77(e)(1)(iv) and (v), regardless of which month(s) of the cost report the residents were on duty, if the response to line 56 is "Y" for yes, enter "Y" for yes in column 1, do not complete column 2, and complete Worksheet E-4.				57.00
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: 15-2014 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-2 Part I Date/Time Prepared: 4/28/2023 10:34 am

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-2014	Period: From 01/01/2022 To 12/31/2022	Worksheet S-2 Part I Date/Time Prepared: 4/28/2023 10:34 am

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-2014 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-2 Part I Date/Time Prepared: 4/28/2023 10:34 am

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

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

		1.00	
	Long Term Care Hospital PPS		
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	Y	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.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-2014 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-2 Part I Date/Time Prepared: 4/28/2023 10:34 am

		V	XIX	
		1.00	2.00	
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	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	109.00

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-2014 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-2 Part I | Date/Time Prepared: 4/28/2023 10:34 am

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	210,056	0	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	N		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	HB0312	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: NAME: SELECT MEDICAL	Contractor's Name: NOVITAS SOLUTIONS INC.	Contractor's Number: 12001	141.00
142.00	Street: STREET: 4714 GETTYSBURG ROAD	PO Box:		142.00
143.00	City: CITY: MECHANICSBURG	State: PA	Zip Code: 17055	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	N	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: 15-2014 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-2 Part I | Date/Time Prepared: 4/28/2023 10:34 am

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

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

			1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act			
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.		N	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)			168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)			168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)		0.00	169.00
		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170.00
		1.00	2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N	0	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-2014 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-2 Part II | Date/Time Prepared: 4/28/2023 10:34 am

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

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-2014 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-2 Part II Date/Time Prepared: 4/28/2023 10:34 am

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

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

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

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	ANDREW	BUTZ	41.00
42.00	Enter the employer/company name of the cost report preparer.	SELECT MEDICAL		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	717-972-1391	APBUTZ@SELECTMEDICAL.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-2014	Period: From 01/01/2022 To 12/31/2022	Worksheet S-2 Part II Date/Time Prepared: 4/28/2023 10:34 am

		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	REIMBRUSEMENT ANALYST		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: 15-2014 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-3 Part I | Date/Time Prepared: 4/28/2023 10:34 am

	Component	Worksheet A Line No.	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	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						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)		60	21,900	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		60				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: 15-2014 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-3 Part I | Date/Time Prepared: 4/28/2023 10:34 am

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	5,548	108	13,686			1.00
2.00	HMO and other (see instructions)	3,691	1,662				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	5,548	108	13,686			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)	5,548	108	13,686	0.00	140.05	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			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	140.05	27.00
28.00	Observation Bed Days		0	0			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care	0	0	0			34.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-2014 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-3 Part I | Date/Time Prepared: 4/28/2023 10:34 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	236	5	528	1.00
2.00	HMO and other (see instructions)			110	65		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	236	5	528	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care						34.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-2014 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-3 Part II Date/Time Prepared: 4/28/2023 10:34 am

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	10,185,255	0	10,185,255	291,312.03	34.96	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician and Non Physician-Part B		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)		0	27,118	27,118	776.24	34.94	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		5,190,401	0	5,190,401	52,201.87	99.43	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		99,381	0	99,381	668.06	148.76	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		1,196,553	0	1,196,553	22,315.00	53.62	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)		1,794,326	0	1,794,326			17.00
18.00	Wage-related costs (other) (see instructions)							18.00
19.00	Excluded areas		5,178	0	5,178			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		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)		206,129	0	206,129			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: 15-2014 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-3 Part II Date/Time Prepared: 4/28/2023 10:34 am

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.53	Home office: Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	0	0	0	0.00	0.00	26.00
27.00	Administrative & General	5.00	1,572,686	-27,118	1,545,568	36,825.51	41.97	27.00
28.00	Administrative & General under contract (see inst.)		0	0	0	0.00	0.00	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	320,082	0	320,082	17,148.29	18.67	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	359,765	0	359,765	18,436.01	19.51	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	475,226	0	475,226	21,685.07	21.91	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	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	626,116	0	626,116	9,536.98	65.65	38.00
39.00	Central Services and Supply	14.00	0	0	0	0.00	0.00	39.00
40.00	Pharmacy	15.00	0	0	0	0.00	0.00	40.00
41.00	Medical Records & Medical Records Library	16.00	84,607	0	84,607	4,035.73	20.96	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-2014 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-3 Part III Date/Time Prepared: 4/28/2023 10:34 am

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		10,185,255	0	10,185,255	291,312.03	34.96	1.00
2.00	Excluded area salaries (see instructions)		0	27,118	27,118	776.24	34.94	2.00
3.00	Subtotal salaries (line 1 minus line 2)		10,185,255	-27,118	10,158,137	290,535.79	34.96	3.00
4.00	Subtotal other wages & related costs (see inst.)		6,486,335	0	6,486,335	75,184.93	86.27	4.00
5.00	Subtotal wage-related costs (see inst.)		2,000,455	0	2,000,455	0.00	19.69	5.00
6.00	Total (sum of lines 3 thru 5)		18,672,045	-27,118	18,644,927	365,720.72	50.98	6.00
7.00	Total overhead cost (see instructions)		3,438,482	-27,118	3,411,364	107,667.59	31.68	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 15-2014 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-3 Part IV Date/Time Prepared: 4/28/2023 10:34 am

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	71,919	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)	718,004	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	12,859	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	23,820	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	0	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	176,741	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	746,207	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	20,111	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	24,666	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	1,794,327	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		25.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-2014 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A | Date/Time Prepared: 4/28/2023 10:34 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		0	0	980,636	980,636	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2,551,160	2,551,160	-1,805,158	746,002	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	8,309	8,309	23,820	32,129	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,572,686	2,921,711	4,494,397	761,879	5,256,276	5.00
7.00	00700	OPERATION OF PLANT	320,082	634,676	954,758	0	954,758	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	170,554	170,554	0	170,554	8.00
9.00	00900	HOUSEKEEPING	359,765	117,350	477,115	0	477,115	9.00
10.00	01000	DIETARY	475,226	370,127	845,353	-164,955	680,398	10.00
11.00	01100	CAFETERIA	0	0	0	164,955	164,955	11.00
13.00	01300	NURSING ADMINISTRATION	626,116	104,658	730,774	0	730,774	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	84,607	26,916	111,523	0	111,523	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,170,837	7,274,699	11,445,536	3,336	11,448,872	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	17,063	104,612	121,675	-23,036	98,639	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	187,256	60,046	247,302	23,036	270,338	54.00
60.00	06000	LABORATORY	0	446,572	446,572	0	446,572	60.00
65.00	06500	RESPIRATORY THERAPY	846,330	573,333	1,419,663	-98,286	1,321,377	65.00
66.00	06600	PHYSICAL THERAPY	263,574	44,869	308,443	0	308,443	66.00
67.00	06700	OCCUPATIONAL THERAPY	292,268	54,063	346,331	0	346,331	67.00
68.00	06800	SPEECH PATHOLOGY	259,546	39,517	299,063	0	299,063	68.00
69.00	06900	ELECTROCARDIOLOGY	0	12,213	12,213	0	12,213	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	99,893	1,420,120	1,520,013	94,950	1,614,963	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	610,006	743,608	1,353,614	0	1,353,614	73.00
74.00	07400	RENAL DIALYSIS	0	414,268	414,268	0	414,268	74.00
76.00	03950	WOUND CARE	0	0	0	0	0	76.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	10,185,255	18,093,381	28,278,636	-38,823	28,239,813	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	PROVIDER RELATIONS NRCC	0	0	0	38,823	38,823	194.00
194.01	07951	NRCC SUBLEASED SPACE	0	0	0	0	0	194.01
194.02	07952	NRCC VACANT SPACE	0	0	0	0	0	194.02
200.00		TOTAL (SUM OF LINES 118 through 199)	10,185,255	18,093,381	28,278,636	0	28,278,636	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-2014 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A | Date/Time Prepared: 4/28/2023 10:34 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	-66,598	914,038		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	88,209	834,211		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	32,129		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,188,980	6,445,256		5.00
7.00	00700	OPERATION OF PLANT	0	954,758		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	170,554		8.00
9.00	00900	HOUSEKEEPING	0	477,115		9.00
10.00	01000	DIETARY	0	680,398		10.00
11.00	01100	CAFETERIA	-20,455	144,500		11.00
13.00	01300	NURSING ADMINISTRATION	0	730,774		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-1,217	110,306		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-693,388	10,755,484		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	98,639		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	270,338		54.00
60.00	06000	LABORATORY	0	446,572		60.00
65.00	06500	RESPIRATORY THERAPY	0	1,321,377		65.00
66.00	06600	PHYSICAL THERAPY	0	308,443		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	346,331		67.00
68.00	06800	SPEECH PATHOLOGY	0	299,063		68.00
69.00	06900	ELECTROCARDIOLOGY	0	12,213		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,614,963		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,353,614		73.00
74.00	07400	RENAL DIALYSIS	0	414,268		74.00
76.00	03950	WOUND CARE	0	0		76.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	495,531	28,735,344		118.00
		NONREIMBURSABLE COST CENTERS				
194.00	07950	PROVIDER RELATIONS NRCC	0	38,823		194.00
194.01	07951	NRCC SUBLEASED SPACE	0	0		194.01
194.02	07952	NRCC VACANT SPACE	0	0		194.02
200.00		TOTAL (SUM OF LINES 118 through 199)	495,531	28,774,167		200.00

RECLASSIFICATIONS | Provider CCN: 15-2014 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-6 | Date/Time Prepared: 4/28/2023 10:34 am

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - FACILITY RENT				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	980,636	1.00
	TOTALS		0	980,636	
	B - EMPLOYEE BENEFITS				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	23,820	1.00
	TOTALS		0	23,820	
	C - CAPITAL RECONCILATION				
1.00	ADMINISTRATIVE & GENERAL	5.00	0	260,035	1.00
	TOTALS		0	260,035	
	D - OPERATING PORTION OF INTEREST				
1.00	ADMINISTRATIVE & GENERAL	5.00	0	564,487	1.00
	TOTALS		0	564,487	
	E - PROVIDER RELATIONS NRCC				
1.00	PROVIDER RELATIONS NRCC	194.00	27,118	11,705	1.00
	TOTALS		27,118	11,705	
	F - OXYGEN TANK RENTAL				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	94,950	1.00
	TOTALS		0	94,950	
	G - SITTER SERVICES				
1.00	ADULTS & PEDIATRICS	30.00	3,336	0	1.00
	TOTALS		3,336	0	
	H - PICC LINE RECLASS				
1.00	RADIOLOGY-DIAGNOSTIC	54.00	0	23,036	1.00
	TOTALS		0	23,036	
	I - DIETARY RECLASS TO CAFETERIA				
1.00	CAFETERIA	11.00	0	164,955	1.00
	TOTALS		0	164,955	
500.00	Grand Total: Increases		30,454	2,123,624	500.00

RECLASSIFICATIONS | Provider CCN: 15-2014 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-6 | Date/Time Prepared: 4/28/2023 10:34 am

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - FACILITY RENT						
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	980,636	10		1.00
	TOTALS		0	980,636			
	B - EMPLOYEE BENEFITS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	23,820	0		1.00
	TOTALS		0	23,820			
	C - CAPITAL RECONCILATION						
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	260,035	12		1.00
	TOTALS		0	260,035			
	D - OPERATING PORTION OF INTEREST						
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	564,487	11		1.00
	TOTALS		0	564,487			
	E - PROVIDER RELATIONS NRCC						
1.00	ADMINISTRATIVE & GENERAL	5.00	27,118	11,705	0		1.00
	TOTALS		27,118	11,705			
	F - OXYGEN TANK RENTAL						
1.00	RESPIRATORY THERAPY	65.00	0	94,950	0		1.00
	TOTALS		0	94,950			
	G - SITTER SERVICES						
1.00	RESPIRATORY THERAPY	65.00	3,336	0	0		1.00
	TOTALS		3,336	0			
	H - PICC LINE RECLASS						
1.00	OPERATING ROOM	50.00	0	23,036	0		1.00
	TOTALS		0	23,036			
	I - DIETARY RECLASS TO CAFETERIA						
1.00	DIETARY	10.00	0	164,955	0		1.00
	TOTALS		0	164,955			
500.00	Grand Total: Decreases		30,454	2,123,624			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-2014 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-7 Part I | Date/Time Prepared: 4/28/2023 10:34 am

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	56,269	14,511	0	14,511	0	1.00
2.00	Land Improvements	0	0	0	0	0	2.00
3.00	Buildings and Fixtures	0	0	0	0	0	3.00
4.00	Building Improvements	2,528,888	296,306	0	296,306	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	8,300,383	12,695	0	12,695	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	10,885,540	323,512	0	323,512	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	10,885,540	323,512	0	323,512	0	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	70,780	0	1.00
2.00	Land Improvements	0	0	2.00
3.00	Buildings and Fixtures	0	0	3.00
4.00	Building Improvements	2,825,194	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	8,313,078	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	11,209,052	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	11,209,052	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-2014 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-7 Part II | Date/Time Prepared: 4/28/2023 10:34 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	722,517	776,906	564,487	263,483	223,767	2.00
3.00	Total (sum of lines 1-2)	722,517	776,906	564,487	263,483	223,767	3.00

	Cost Center Description	SUMMARY OF CAPITAL			
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)		
		14.00	15.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2				
1.00	CAP REL COSTS-BLDG & FIXT	0	0		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	2,551,160		2.00
3.00	Total (sum of lines 1-2)	0	2,551,160		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-2014 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-7 Part III Date/Time Prepared: 4/28/2023 10:34 am

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	2,895,974	0	2,895,974	0.258360	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	8,313,078	0	8,313,078	0.741640	0	2.00
3.00	Total (sum of lines 1-2)	11,209,052	0	11,209,052	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	914,038	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	810,726	-203,730	2.00
3.00	Total (sum of lines 1-2)	0	0	0	810,726	710,308	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	914,038	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	3,448	223,767	0	834,211	2.00
3.00	Total (sum of lines 1-2)	0	3,448	223,767	0	1,748,249	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-2014 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-8 | Date/Time Prepared: 4/28/2023 10:34 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		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)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-693,388			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	1,147,480			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests		0		0.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-2014 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-8 | Date/Time Prepared: 4/28/2023 10:34 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.00
34.00	OTHER PERSONNEL EXPENSE	A	-32,215	ADMINISTRATIVE & GENERAL	5.00	0	34.00
35.00	AHA DUES	A	-1,571	ADMINISTRATIVE & GENERAL	5.00	0	35.00
36.00	MEDICAL RECORDS INCOME	B	-1,217	MEDICAL RECORDS & LIBRARY	16.00	0	36.00
37.00	DIETARY CAFETERIA INCOME	B	-18,794	CAFETERIA	11.00	0	37.00
38.00	REVERSE OF GL EXP CR FOR CARES	A	96,994	ADMINISTRATIVE & GENERAL	5.00	0	38.00
39.00	GIFTS	A	-97	ADMINISTRATIVE & GENERAL	5.00	0	39.00
40.00	CAFETERIA VENDING REVENUE	B	-1,661	CAFETERIA	11.00	0	40.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		495,531				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: 15-2014 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-8-1 | Date/Time Prepared: 4/28/2023 10:34 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	2.00	CAP REL COSTS-MVBLE EQUIP	HOME OFFICE CAPITAL	88,209	0	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE ADMIN	1,868,515	742,646	2.00
3.00	1.00	CAP REL COSTS-BLDG & FIXT	SMPV	710,309	776,907	3.00
4.00	0.00			0	0	4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			2,667,033	1,519,553	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	SELECT MEDICAL	100.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 15-2014 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-8-1 | Date/Time Prepared: 4/28/2023 10:34 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	88,209	9		1.00
2.00	1,125,869	0		2.00
3.00	-66,598	10		3.00
4.00	0	0		4.00
5.00	1,147,480			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			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: 15-2014 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-8-2 | Date/Time Prepared: 4/28/2023 10:34 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	DR. A	8,556	0	8,556	211,500	122	1.00
2.00	30.00	DR. B	6,400	0	6,400	211,500	40	2.00
3.00	30.00	DR. C	11,220	0	11,220	211,500	60	3.00
4.00	30.00	DR. D	13,831	0	13,831	211,500	79	4.00
5.00	30.00	DR. E	29,213	0	29,213	211,500	195	5.00
6.00	30.00	DR. F	19,210	0	19,210	211,500	113	6.00
7.00	30.00	DR. G	112,976	112,976	0	211,500	0	7.00
8.00	30.00	DR. H	160,542	0	160,542	211,500	4,569	8.00
9.00	30.00	DR. I	6,600	6,600	0	211,500	0	9.00
10.00	30.00	DR. J	34,650	0	34,650	211,500	5,544	10.00
11.00	30.00	DR. K	492,480	159,131	333,349	211,500	2,963	11.00
12.00	30.00	DR. L	529,425	193,799	335,626	211,500	2,754	12.00
13.00	30.00	DR. M	142,325	25,825	116,500	211,500	388	13.00
200.00			1,567,428	498,331	1,069,097		16,827	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	DR. A	12,405	620	0	0	0	1.00
2.00	30.00	DR. B	4,067	203	0	0	0	2.00
3.00	30.00	DR. C	6,101	305	0	0	0	3.00
4.00	30.00	DR. D	8,033	402	0	0	0	4.00
5.00	30.00	DR. E	19,828	991	0	0	0	5.00
6.00	30.00	DR. F	11,490	575	0	0	0	6.00
7.00	30.00	DR. G	0	0	0	0	0	7.00
8.00	30.00	DR. H	464,588	23,229	0	0	0	8.00
9.00	30.00	DR. I	0	0	0	0	0	9.00
10.00	30.00	DR. J	563,729	28,186	0	0	0	10.00
11.00	30.00	DR. K	301,286	15,064	0	0	0	11.00
12.00	30.00	DR. L	280,034	14,002	0	0	0	12.00
13.00	30.00	DR. M	39,453	1,973	0	0	0	13.00
200.00			1,711,014	85,550	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	DR. A	0	12,405	0	0		1.00
2.00	30.00	DR. B	0	4,067	2,333	2,333		2.00
3.00	30.00	DR. C	0	6,101	5,119	5,119		3.00
4.00	30.00	DR. D	0	8,033	5,798	5,798		4.00
5.00	30.00	DR. E	0	19,828	9,385	9,385		5.00
6.00	30.00	DR. F	0	11,490	7,720	7,720		6.00
7.00	30.00	DR. G	0	0	0	112,976		7.00
8.00	30.00	DR. H	0	464,588	0	0		8.00
9.00	30.00	DR. I	0	0	0	6,600		9.00
10.00	30.00	DR. J	0	563,729	0	0		10.00
11.00	30.00	DR. K	0	301,286	32,063	191,194		11.00
12.00	30.00	DR. L	0	280,034	55,592	249,391		12.00
13.00	30.00	DR. M	0	39,453	77,047	102,872		13.00
200.00			0	1,711,014	195,057	693,388		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-2014 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part I Date/Time Prepared: 4/28/2023 10:34 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	914,038	914,038				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	834,211		834,211			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	32,129	0	0	32,129		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	6,445,256	581,403	604,423	4,875	7,635,957	5.00
7.00	00700	OPERATION OF PLANT	954,758	0	0	1,010	955,768	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	170,554	0	0	0	170,554	8.00
9.00	00900	HOUSEKEEPING	477,115	0	0	1,135	478,250	9.00
10.00	01000	DIETARY	680,398	39,928	41,509	1,499	763,334	10.00
11.00	01100	CAFETERIA	144,500	21,610	22,465	0	188,575	11.00
13.00	01300	NURSING ADMINISTRATION	730,774	0	0	1,975	732,749	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	110,306	0	0	267	110,573	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	10,755,484	138,307	143,783	13,167	11,050,741	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	98,639	0	0	54	98,693	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	270,338	7,143	7,426	591	285,498	54.00
60.00	06000	LABORATORY	446,572	1,236	1,285	0	449,093	60.00
65.00	06500	RESPIRATORY THERAPY	1,321,377	1,978	2,056	2,659	1,328,070	65.00
66.00	06600	PHYSICAL THERAPY	308,443	7,500	7,797	831	324,571	66.00
67.00	06700	OCCUPATIONAL THERAPY	346,331	0	0	922	347,253	67.00
68.00	06800	SPEECH PATHOLOGY	299,063	0	0	819	299,882	68.00
69.00	06900	ELECTROCARDIOLOGY	12,213	0	0	0	12,213	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,614,963	0	0	315	1,615,278	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,353,614	2,610	2,713	1,924	1,360,861	73.00
74.00	07400	RENAL DIALYSIS	414,268	0	0	0	414,268	74.00
76.00	03950	WOUND CARE	0	0	0	0	0	76.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	28,735,344	801,715	833,457	32,043	28,622,181	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	PROVIDER RELATIONS NRCC	38,823	725	754	86	40,388	194.00
194.01	07951	NRCC SUBLEASED SPACE	0	0	0	0	0	194.01
194.02	07952	NRCC VACANT SPACE	0	111,598	0	0	111,598	194.02
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)	28,774,167	914,038	834,211	32,129	28,774,167	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-2014 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part I Date/Time Prepared: 4/28/2023 10:34 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	7,635,957					5.00
7.00	00700	OPERATION OF PLANT	347,094	1,302,862				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	61,938	0	232,492			8.00
9.00	00900	HOUSEKEEPING	173,680	0	0	651,930		9.00
10.00	01000	DIETARY	277,210	235,350	0	117,765	1,393,659	10.00
11.00	01100	CAFETERIA	68,482	127,375	0	63,736	0	11.00
13.00	01300	NURSING ADMINISTRATION	266,103	0	0	0	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	40,155	0	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,013,151	815,224	232,492	407,925	1,393,659	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	35,841	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	103,681	42,102	0	21,067	0	54.00
60.00	06000	LABORATORY	163,091	7,287	0	3,646	0	60.00
65.00	06500	RESPIRATORY THERAPY	482,298	11,659	0	5,834	0	65.00
66.00	06600	PHYSICAL THERAPY	117,870	44,207	0	22,120	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	126,107	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	108,904	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	4,435	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	586,600	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	494,206	15,383	0	7,698	0	73.00
74.00	07400	RENAL DIALYSIS	150,444	0	0	0	0	74.00
76.00	03950	WOUND CARE	0	0	0	0	0	76.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	7,621,290	1,298,587	232,492	649,791	1,393,659	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	PROVIDER RELATIONS NRCC	14,667	4,275	0	2,139	0	194.00
194.01	07951	NRCC SUBLEASED SPACE	0	0	0	0	0	194.01
194.02	07952	NRCC VACANT SPACE	0	0	0	0	0	194.02
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)	7,635,957	1,302,862	232,492	651,930	1,393,659	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-2014 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part I Date/Time Prepared: 4/28/2023 10:34 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			11.00	13.00	16.00	24.00	25.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	448,168					11.00
13.00	01300	NURSING ADMINISTRATION	21,667	1,020,519				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	9,189	0	159,917			16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	260,730	1,020,519	48,981	19,243,422	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	236	134,770	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	20,766	0	1,865	474,979	0	54.00
60.00	06000	LABORATORY	0	0	7,652	630,769	0	60.00
65.00	06500	RESPIRATORY THERAPY	46,263	0	60,987	1,935,111	0	65.00
66.00	06600	PHYSICAL THERAPY	17,253	0	3,264	529,285	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	17,929	0	2,732	494,021	0	67.00
68.00	06800	SPEECH PATHOLOGY	12,118	0	3,022	423,926	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	9,890	26,538	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	9,144	0	9,718	2,220,740	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	28,379	0	9,250	1,915,777	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	2,320	567,032	0	74.00
76.00	03950	WOUND CARE	0	0	0	0	0	76.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	443,438	1,020,519	159,917	28,596,370	0	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	PROVIDER RELATIONS NRCC	4,730	0	0	66,199	0	194.00
194.01	07951	NRCC SUBLEASED SPACE	0	0	0	0	0	194.01
194.02	07952	NRCC VACANT SPACE	0	0	0	111,598	0	194.02
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	448,168	1,020,519	159,917	28,774,167	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-2014 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part I | Date/Time Prepared: 4/28/2023 10:34 am

		Cost Center Description	Total		
			26.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
7.00	00700	OPERATION OF PLANT			7.00
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
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	19,243,422		30.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	134,770		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	474,979		54.00
60.00	06000	LABORATORY	630,769		60.00
65.00	06500	RESPIRATORY THERAPY	1,935,111		65.00
66.00	06600	PHYSICAL THERAPY	529,285		66.00
67.00	06700	OCCUPATIONAL THERAPY	494,021		67.00
68.00	06800	SPEECH PATHOLOGY	423,926		68.00
69.00	06900	ELECTROCARDIOLOGY	26,538		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,220,740		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,915,777		73.00
74.00	07400	RENAL DIALYSIS	567,032		74.00
76.00	03950	WOUND CARE	0		76.00
		SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	28,596,370		118.00
		NONREIMBURSABLE COST CENTERS			
194.00	07950	PROVIDER RELATIONS NRCC	66,199		194.00
194.01	07951	NRCC SUBLEASED SPACE	0		194.01
194.02	07952	NRCC VACANT SPACE	111,598		194.02
200.00		Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118 through 201)	28,774,167		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-2014 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part II Date/Time Prepared: 4/28/2023 10:34 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	581,403	604,423	1,185,826	0	5.00
7.00	00700	OPERATION OF PLANT	10,107	0	0	10,107	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	0	0	0	0	9.00
10.00	01000	DIETARY	0	39,928	41,509	81,437	0	10.00
11.00	01100	CAFETERIA	0	21,610	22,465	44,075	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	138,307	143,783	282,090	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	7,143	7,426	14,569	0	54.00
60.00	06000	LABORATORY	0	1,236	1,285	2,521	0	60.00
65.00	06500	RESPIRATORY THERAPY	94,950	1,978	2,056	98,984	0	65.00
66.00	06600	PHYSICAL THERAPY	0	7,500	7,797	15,297	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	270,059	0	0	270,059	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,610	2,713	5,323	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	WOUND CARE	0	0	0	0	0	76.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	375,116	801,715	833,457	2,010,288	0	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	PROVIDER RELATIONS NRCC	0	725	754	1,479	0	194.00
194.01	07951	NRCC SUBLEASED SPACE	0	0	0	0	0	194.01
194.02	07952	NRCC VACANT SPACE	0	111,598	0	111,598	0	194.02
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)	375,116	914,038	834,211	2,123,365	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-2014 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part II | Date/Time Prepared: 4/28/2023 10:34 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,185,826					5.00
7.00	00700	OPERATION OF PLANT	53,901	64,008				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	9,619	0	9,619			8.00
9.00	00900	HOUSEKEEPING	26,971	0	0	26,971		9.00
10.00	01000	DIETARY	43,049	11,562	0	4,872	140,920	10.00
11.00	01100	CAFETERIA	10,635	6,258	0	2,637	0	11.00
13.00	01300	NURSING ADMINISTRATION	41,324	0	0	0	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	6,236	0	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	623,226	40,051	9,619	16,877	140,920	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,566	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	16,101	2,068	0	872	0	54.00
60.00	06000	LABORATORY	25,327	358	0	151	0	60.00
65.00	06500	RESPIRATORY THERAPY	74,898	573	0	241	0	65.00
66.00	06600	PHYSICAL THERAPY	18,305	2,172	0	915	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	19,584	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	16,912	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	689	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	91,095	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	76,747	756	0	318	0	73.00
74.00	07400	RENAL DIALYSIS	23,363	0	0	0	0	74.00
76.00	03950	WOUND CARE	0	0	0	0	0	76.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,183,548	63,798	9,619	26,883	140,920	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	PROVIDER RELATIONS NRCC	2,278	210	0	88	0	194.00
194.01	07951	NRCC SUBLEASED SPACE	0	0	0	0	0	194.01
194.02	07952	NRCC VACANT SPACE	0	0	0	0	0	194.02
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)	1,185,826	64,008	9,619	26,971	140,920	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-2014 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part II Date/Time Prepared: 4/28/2023 10:34 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			11.00	13.00	16.00	24.00	25.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	63,605					11.00
13.00	01300	NURSING ADMINISTRATION	3,075	44,399				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,304	0	7,540			16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	37,003	44,399	2,290	1,196,475	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	11	5,577	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,947	0	87	36,644	0	54.00
60.00	06000	LABORATORY	0	0	358	28,715	0	60.00
65.00	06500	RESPIRATORY THERAPY	6,566	0	2,914	184,176	0	65.00
66.00	06600	PHYSICAL THERAPY	2,449	0	153	39,291	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,544	0	128	22,256	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,720	0	141	18,773	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	462	1,151	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,298	0	454	362,906	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,028	0	433	87,605	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	109	23,472	0	74.00
76.00	03950	WOUND CARE	0	0	0	0	0	76.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	62,934	44,399	7,540	2,007,041	0	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	PROVIDER RELATIONS NRCC	671	0	0	4,726	0	194.00
194.01	07951	NRCC SUBLEASED SPACE	0	0	0	0	0	194.01
194.02	07952	NRCC VACANT SPACE	0	0	0	111,598	0	194.02
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	63,605	44,399	7,540	2,123,365	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-2014 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part II | Date/Time Prepared: 4/28/2023 10:34 am

		Cost Center Description	Total		
			26.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
7.00	00700	OPERATION OF PLANT			7.00
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
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	1,196,475		30.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	5,577		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	36,644		54.00
60.00	06000	LABORATORY	28,715		60.00
65.00	06500	RESPIRATORY THERAPY	184,176		65.00
66.00	06600	PHYSICAL THERAPY	39,291		66.00
67.00	06700	OCCUPATIONAL THERAPY	22,256		67.00
68.00	06800	SPEECH PATHOLOGY	18,773		68.00
69.00	06900	ELECTROCARDIOLOGY	1,151		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	362,906		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	87,605		73.00
74.00	07400	RENAL DIALYSIS	23,472		74.00
76.00	03950	WOUND CARE	0		76.00
		SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,007,041		118.00
		NONREIMBURSABLE COST CENTERS			
194.00	07950	PROVIDER RELATIONS NRCC	4,726		194.00
194.01	07951	NRCC SUBLEASED SPACE	0		194.01
194.02	07952	NRCC VACANT SPACE	111,598		194.02
200.00		Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118 through 201)	2,123,365		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-2014 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B-1 | Date/Time Prepared: 4/28/2023 10:34 am

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	166,356					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		146,045				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	10,185,255			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	105,816	105,816	1,545,568	-7,635,957	21,026,612	5.00
7.00	00700	OPERATION OF PLANT	0	0	320,082	0	955,768	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	170,554	8.00
9.00	00900	HOUSEKEEPING	0	0	359,765	0	478,250	9.00
10.00	01000	DIETARY	7,267	7,267	475,226	0	763,334	10.00
11.00	01100	CAFETERIA	3,933	3,933	0	0	188,575	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	626,116	0	732,749	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	84,607	0	110,573	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	25,172	25,172	4,174,173	0	11,050,741	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	17,063	0	98,693	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,300	1,300	187,256	0	285,498	54.00
60.00	06000	LABORATORY	225	225	0	0	449,093	60.00
65.00	06500	RESPIRATORY THERAPY	360	360	842,994	0	1,328,070	65.00
66.00	06600	PHYSICAL THERAPY	1,365	1,365	263,574	0	324,571	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	292,268	0	347,253	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	259,546	0	299,882	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	12,213	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	99,893	0	1,615,278	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	475	475	610,006	0	1,360,861	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	414,268	74.00
76.00	03950	WOUND CARE	0	0	0	0	0	76.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	145,913	145,913	10,158,137	-7,635,957	20,986,224	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	PROVIDER RELATIONS NRCC	132	132	27,118	0	40,388	194.00
194.01	07951	NRCC SUBLEASED SPACE	0	0	0	0	0	194.01
194.02	07952	NRCC VACANT SPACE	20,311	0	0	-111,598	0	194.02
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)	914,038	834,211	32,129		7,635,957	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	5.494470	5.712013	0.003154		0.363157	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			0		1,185,826	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000000		0.056396	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: 15-2014 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B-1 | Date/Time Prepared: 4/28/2023 10:34 am

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	CAFETERIA (MEALS SERVED)	
			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	40,229					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	13,686				8.00
9.00	00900	HOUSEKEEPING	0	0	40,229			9.00
10.00	01000	DIETARY	7,267	0	7,267	13,686		10.00
11.00	01100	CAFETERIA	3,933	0	3,933	0	9,949	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	481	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	204	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	25,172	13,686	25,172	13,686	5,788	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,300	0	1,300	0	461	54.00
60.00	06000	LABORATORY	225	0	225	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	360	0	360	0	1,027	65.00
66.00	06600	PHYSICAL THERAPY	1,365	0	1,365	0	383	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	398	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	269	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	203	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	475	0	475	0	630	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	WOUND CARE	0	0	0	0	0	76.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	40,097	13,686	40,097	13,686	9,844	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	PROVIDER RELATIONS NRCC	132	0	132	0	105	194.00
194.01	07951	NRCC SUBLEASED SPACE	0	0	0	0	0	194.01
194.02	07952	NRCC VACANT SPACE	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,302,862	232,492	651,930	1,393,659	448,168	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	32.386139	16.987579	16.205474	101.830995	45.046537	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	64,008	9,619	26,971	140,920	63,605	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1.591091	0.702835	0.670437	10.296654	6.393105	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: 15-2014 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B-1 | Date/Time Prepared: 4/28/2023 10:34 am

		Cost Center Description	NURSING ADMINISTRATION (NURSING FTE'S)	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)		
			13.00	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				11.00
13.00	01300	NURSING ADMINISTRATION	55			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	131,151,026		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	55	40,180,974		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	193,320		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,529,661		54.00
60.00	06000	LABORATORY	0	6,276,951		60.00
65.00	06500	RESPIRATORY THERAPY	0	49,994,379		65.00
66.00	06600	PHYSICAL THERAPY	0	2,677,581		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,241,171		67.00
68.00	06800	SPEECH PATHOLOGY	0	2,479,372		68.00
69.00	06900	ELECTROCARDIOLOGY	0	8,113,480		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	7,972,048		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	7,588,544		73.00
74.00	07400	RENAL DIALYSIS	0	1,903,545		74.00
76.00	03950	WOUND CARE	0	0		76.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	55	131,151,026		118.00
		NONREIMBURSABLE COST CENTERS				
194.00	07950	PROVIDER RELATIONS NRCC	0	0		194.00
194.01	07951	NRCC SUBLEASED SPACE	0	0		194.01
194.02	07952	NRCC VACANT SPACE	0	0		194.02
200.00		Cross Foot Adjustments				200.00
201.00		Negative Cost Centers				201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,020,519	159,917		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	18,554.890909	0.001219		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	44,399	7,540		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	807.254545	0.000057		205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)				206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)				207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-2014 | Period: From 01/01/2022 To 12/31/2022 | Worksheet C Part I Date/Time Prepared: 4/28/2023 10:34 am

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		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	19,243,422		19,243,422	195,057	19,438,479	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	134,770		134,770	0	134,770	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	474,979		474,979	0	474,979	54.00
60.00	06000	LABORATORY	630,769		630,769	0	630,769	60.00
65.00	06500	RESPIRATORY THERAPY	1,935,111	0	1,935,111	0	1,935,111	65.00
66.00	06600	PHYSICAL THERAPY	529,285	0	529,285	0	529,285	66.00
67.00	06700	OCCUPATIONAL THERAPY	494,021	0	494,021	0	494,021	67.00
68.00	06800	SPEECH PATHOLOGY	423,926	0	423,926	0	423,926	68.00
69.00	06900	ELECTROCARDIOLOGY	26,538		26,538	0	26,538	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,220,740		2,220,740	0	2,220,740	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,915,777		1,915,777	0	1,915,777	73.00
74.00	07400	RENAL DIALYSIS	567,032		567,032	0	567,032	74.00
76.00	03950	WOUND CARE	0		0	0	0	76.00
200.00		Subtotal (see instructions)	28,596,370	0	28,596,370	195,057	28,791,427	200.00
201.00		Less Observation Beds	0		0		0	201.00
202.00		Total (see instructions)	28,596,370	0	28,596,370	195,057	28,791,427	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-2014 | Period: From 01/01/2022 To 12/31/2022 | Worksheet C Part I Date/Time Prepared: 4/28/2023 10:34 am

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		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	40,180,974		40,180,974			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	193,320	0	193,320	0.697134	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,529,661	0	1,529,661	0.310513	0.000000	54.00
60.00	06000	LABORATORY	6,276,951	0	6,276,951	0.100490	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	49,994,379	0	49,994,379	0.038707	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	2,677,581	0	2,677,581	0.197673	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,241,171	0	2,241,171	0.220430	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	2,479,372	0	2,479,372	0.170981	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	8,113,480	0	8,113,480	0.003271	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	7,972,048	0	7,972,048	0.278566	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,588,544	0	7,588,544	0.252456	0.000000	73.00
74.00	07400	RENAL DIALYSIS	1,903,545	0	1,903,545	0.297882	0.000000	74.00
76.00	03950	WOUND CARE	0	0	0	0.000000	0.000000	76.00
200.00		Subtotal (see instructions)	131,151,026	0	131,151,026			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	131,151,026	0	131,151,026			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-2014 | Period: From 01/01/2022 To 12/31/2022 | Worksheet C Part I Date/Time Prepared: 4/28/2023 10:34 am

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		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.697134		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.310513		54.00
60.00	06000	LABORATORY	0.100490		60.00
65.00	06500	RESPIRATORY THERAPY	0.038707		65.00
66.00	06600	PHYSICAL THERAPY	0.197673		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.220430		67.00
68.00	06800	SPEECH PATHOLOGY	0.170981		68.00
69.00	06900	ELECTROCARDIOLOGY	0.003271		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.278566		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.252456		73.00
74.00	07400	RENAL DIALYSIS	0.297882		74.00
76.00	03950	WOUND CARE	0.000000		76.00
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: 15-2014 | Period: From 01/01/2022 To 12/31/2022 | Worksheet C Part I Date/Time Prepared: 4/28/2023 10:34 am

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		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	19,243,422		19,243,422	195,057	19,438,479	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	134,770		134,770	0	134,770	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	474,979		474,979	0	474,979	54.00
60.00	06000	LABORATORY	630,769		630,769	0	630,769	60.00
65.00	06500	RESPIRATORY THERAPY	1,935,111	0	1,935,111	0	1,935,111	65.00
66.00	06600	PHYSICAL THERAPY	529,285	0	529,285	0	529,285	66.00
67.00	06700	OCCUPATIONAL THERAPY	494,021	0	494,021	0	494,021	67.00
68.00	06800	SPEECH PATHOLOGY	423,926	0	423,926	0	423,926	68.00
69.00	06900	ELECTROCARDIOLOGY	26,538		26,538	0	26,538	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,220,740		2,220,740	0	2,220,740	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,915,777		1,915,777	0	1,915,777	73.00
74.00	07400	RENAL DIALYSIS	567,032		567,032	0	567,032	74.00
76.00	03950	WOUND CARE	0		0	0	0	76.00
200.00		Subtotal (see instructions)	28,596,370	0	28,596,370	195,057	28,791,427	200.00
201.00		Less Observation Beds	0		0		0	201.00
202.00		Total (see instructions)	28,596,370	0	28,596,370	195,057	28,791,427	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-2014 | Period: From 01/01/2022 To 12/31/2022 | Worksheet C Part I Date/Time Prepared: 4/28/2023 10:34 am

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		Cost Center Description	Charges					
			Inpatient	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	40,180,974		40,180,974			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	193,320	0	193,320	0.697134	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,529,661	0	1,529,661	0.310513	0.000000	54.00
60.00	06000	LABORATORY	6,276,951	0	6,276,951	0.100490	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	49,994,379	0	49,994,379	0.038707	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	2,677,581	0	2,677,581	0.197673	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,241,171	0	2,241,171	0.220430	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	2,479,372	0	2,479,372	0.170981	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	8,113,480	0	8,113,480	0.003271	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	7,972,048	0	7,972,048	0.278566	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,588,544	0	7,588,544	0.252456	0.000000	73.00
74.00	07400	RENAL DIALYSIS	1,903,545	0	1,903,545	0.297882	0.000000	74.00
76.00	03950	WOUND CARE	0	0	0	0.000000	0.000000	76.00
200.00		Subtotal (see instructions)	131,151,026	0	131,151,026			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	131,151,026	0	131,151,026			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-2014 | Period: From 01/01/2022 To 12/31/2022 | Worksheet C Part I Date/Time Prepared: 4/28/2023 10:34 am

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		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.697134		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.310513		54.00
60.00	06000	LABORATORY	0.100490		60.00
65.00	06500	RESPIRATORY THERAPY	0.038707		65.00
66.00	06600	PHYSICAL THERAPY	0.197673		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.220430		67.00
68.00	06800	SPEECH PATHOLOGY	0.170981		68.00
69.00	06900	ELECTROCARDIOLOGY	0.003271		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.278566		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.252456		73.00
74.00	07400	RENAL DIALYSIS	0.297882		74.00
76.00	03950	WOUND CARE	0.000000		76.00
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: 15-2014 | Period: From 01/01/2022 To 12/31/2022 | Worksheet C Part II | Date/Time Prepared: 4/28/2023 10:34 am

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	134,770	5,577	129,193	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	474,979	36,644	438,335	0	0	54.00
60.00	06000	LABORATORY	630,769	28,715	602,054	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,935,111	184,176	1,750,935	0	0	65.00
66.00	06600	PHYSICAL THERAPY	529,285	39,291	489,994	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	494,021	22,256	471,765	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	423,926	18,773	405,153	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	26,538	1,151	25,387	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,220,740	362,906	1,857,834	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,915,777	87,605	1,828,172	0	0	73.00
74.00	07400	RENAL DIALYSIS	567,032	23,472	543,560	0	0	74.00
76.00	03950	WOUND CARE	0	0	0	0	0	76.00
200.00		Subtotal (sum of lines 50 thru 199)	9,352,948	810,566	8,542,382	0	0	200.00
201.00		Less Observation Beds	0	0	0	0	0	201.00
202.00		Total (line 200 minus line 201)	9,352,948	810,566	8,542,382	0	0	202.00

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

Provider CCN: 15-2014 | Period: From 01/01/2022 To 12/31/2022 | Worksheet C Part II | Date/Time Prepared: 4/28/2023 10:34 am

Title XIX | Hospital | PPS

		Cost Center Description	Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)		
			6.00	7.00	8.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	134,770	193,320	0.697134		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	474,979	1,529,661	0.310513		54.00
60.00	06000	LABORATORY	630,769	6,276,951	0.100490		60.00
65.00	06500	RESPIRATORY THERAPY	1,935,111	49,994,379	0.038707		65.00
66.00	06600	PHYSICAL THERAPY	529,285	2,677,581	0.197673		66.00
67.00	06700	OCCUPATIONAL THERAPY	494,021	2,241,171	0.220430		67.00
68.00	06800	SPEECH PATHOLOGY	423,926	2,479,372	0.170981		68.00
69.00	06900	ELECTROCARDIOLOGY	26,538	8,113,480	0.003271		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,220,740	7,972,048	0.278566		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,915,777	7,588,544	0.252456		73.00
74.00	07400	RENAL DIALYSIS	567,032	1,903,545	0.297882		74.00
76.00	03950	WOUND CARE	0	0	0.000000		76.00
200.00		Subtotal (sum of lines 50 thru 199)	9,352,948	90,970,052			200.00
201.00		Less Observation Beds	0	0			201.00
202.00		Total (line 200 minus line 201)	9,352,948	90,970,052			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-2014 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part I Date/Time Prepared: 4/28/2023 10:34 am

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,196,475	0	1,196,475	13,686	87.42	30.00
200.00	Total (lines 30 through 199)	1,196,475		1,196,475	13,686		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	5,548	485,006	30.00
200.00	Total (lines 30 through 199)	5,548	485,006	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-2014 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part II Date/Time Prepared: 4/28/2023 10:34 am

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,577	193,320	0.028849	145,277	4,191	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	36,644	1,529,661	0.023956	676,055	16,196	54.00
60.00	06000	LABORATORY	28,715	6,276,951	0.004575	2,845,714	13,019	60.00
65.00	06500	RESPIRATORY THERAPY	184,176	49,994,379	0.003684	20,155,143	74,252	65.00
66.00	06600	PHYSICAL THERAPY	39,291	2,677,581	0.014674	1,087,944	15,964	66.00
67.00	06700	OCCUPATIONAL THERAPY	22,256	2,241,171	0.009931	923,888	9,175	67.00
68.00	06800	SPEECH PATHOLOGY	18,773	2,479,372	0.007572	994,639	7,531	68.00
69.00	06900	ELECTROCARDIOLOGY	1,151	8,113,480	0.000142	3,445,157	489	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	362,906	7,972,048	0.045522	3,632,565	165,362	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	87,605	7,588,544	0.011544	3,079,309	35,548	73.00
74.00	07400	RENAL DIALYSIS	23,472	1,903,545	0.012331	762,016	9,396	74.00
76.00	03950	WOUND CARE	0	0	0.000000	0	0	76.00
200.00		Total (lines 50 through 199)	810,566	90,970,052		37,747,707	351,123	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-2014 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part III Date/Time Prepared: 4/28/2023 10:34 am

Title XVIII | Hospital | PPS

		Cost Center Description	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
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	13,686	0.00	5,548	30.00
200.00		Total (lines 30 through 199)		0	13,686		5,548	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
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-2014 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part IV Date/Time Prepared: 4/28/2023 10:34 am

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
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	WOUND CARE	0	0	0	0	0	76.00
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: 15-2014 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part IV Date/Time Prepared: 4/28/2023 10:34 am

Title XVIII | 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	193,320	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	1,529,661	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	6,276,951	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	49,994,379	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,677,581	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	2,241,171	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	2,479,372	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	8,113,480	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	7,972,048	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	7,588,544	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	1,903,545	0.000000	74.00
76.00	03950	WOUND CARE	0	0	0	0	0.000000	76.00
200.00		Total (lines 50 through 199)	0	0	0	90,970,052		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-2014 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part IV Date/Time Prepared: 4/28/2023 10:34 am

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	145,277	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	676,055	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	2,845,714	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	20,155,143	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	1,087,944	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	923,888	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	994,639	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	3,445,157	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	3,632,565	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	3,079,309	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	762,016	0	0	0	74.00
76.00	03950	WOUND CARE	0.000000	0	0	0	0	76.00
200.00		Total (lines 50 through 199)		37,747,707	0	0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-2014 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part I Date/Time Prepared: 4/28/2023 10:34 am

Title XIX | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,196,475	0	1,196,475	13,686	87.42	30.00
200.00	Total (lines 30 through 199)	1,196,475		1,196,475	13,686		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	108	9,441				30.00
200.00	Total (lines 30 through 199)	108	9,441				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-2014 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part II Date/Time Prepared: 4/28/2023 10:34 am

Title XIX | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,577	193,320	0.028849	5,579	161	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	36,644	1,529,661	0.023956	13,029	312	54.00
60.00	06000	LABORATORY	28,715	6,276,951	0.004575	35,893	164	60.00
65.00	06500	RESPIRATORY THERAPY	184,176	49,994,379	0.003684	625,569	2,305	65.00
66.00	06600	PHYSICAL THERAPY	39,291	2,677,581	0.014674	13,122	193	66.00
67.00	06700	OCCUPATIONAL THERAPY	22,256	2,241,171	0.009931	13,341	132	67.00
68.00	06800	SPEECH PATHOLOGY	18,773	2,479,372	0.007572	11,076	84	68.00
69.00	06900	ELECTROCARDIOLOGY	1,151	8,113,480	0.000142	63,049	9	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	362,906	7,972,048	0.045522	35,163	1,601	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	87,605	7,588,544	0.011544	63,679	735	73.00
74.00	07400	RENAL DIALYSIS	23,472	1,903,545	0.012331	0	0	74.00
76.00	03950	WOUND CARE	0	0	0.000000	0	0	76.00
200.00		Total (lines 50 through 199)	810,566	90,970,052		879,500	5,696	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-2014 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part III Date/Time Prepared: 4/28/2023 10:34 am

Title XIX | Hospital | PPS

		Cost Center Description	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
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	13,686	0.00	108	30.00
200.00		Total (lines 30 through 199)		0	13,686		108	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
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-2014 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part IV | Date/Time Prepared: 4/28/2023 10:34 am

Title XIX | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
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	WOUND CARE	0	0	0	0	0	76.00
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: 15-2014 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part IV Date/Time Prepared: 4/28/2023 10:34 am

Title XIX | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	193,320	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	1,529,661	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	6,276,951	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	49,994,379	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,677,581	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	2,241,171	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	2,479,372	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	8,113,480	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	7,972,048	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	7,588,544	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	1,903,545	0.000000	74.00
76.00	03950	WOUND CARE	0	0	0	0	0.000000	76.00
200.00		Total (lines 50 through 199)	0	0	0	90,970,052		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-2014 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part IV | Date/Time Prepared: 4/28/2023 10:34 am

Title XIX | Hospital | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	5,579	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	13,029	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	35,893	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	625,569	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	13,122	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	13,341	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	11,076	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	63,049	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	35,163	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	63,679	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
76.00	03950	WOUND CARE	0.000000	0	0	0	0	76.00
200.00		Total (lines 50 through 199)		879,500	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-2014 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-1 | Date/Time Prepared: 4/28/2023 10:34 am

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)	13,686	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	13,686	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)	13,686	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	5,548	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	19,438,479	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)	19,438,479	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)	19,438,479	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)	1,420.32	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	7,879,935	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)	7,879,935	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-2014 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-1 | Date/Time Prepared: 4/28/2023 10:34 am

Title XVIII | Hospital | PPS

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	3,993,646	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)	11,873,581	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)	485,006	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	351,123	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	836,129	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	11,037,452	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
55.01	Permanent adjustment amount per discharge	0.00	55.01
55.02	Adjustment amount per discharge (contractor use only)	0.00	55.02
56.00	Target amount (line 54 x sum of lines 55, 55.01, and 55.02)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)	0.00	59.00
60.00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)	0.00	60.00
61.00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-2014 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-1 | Date/Time Prepared: 4/28/2023 10:34 am

Title XVIII | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	1,196,475	19,438,479	0.061552	0	0	90.00
91.00	Nursing Program cost	0	19,438,479	0.000000	0	0	91.00
92.00	Allied health cost	0	19,438,479	0.000000	0	0	92.00
93.00	All other Medical Education	0	19,438,479	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-2014 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-1 | Date/Time Prepared: 4/28/2023 10:34 am

Title XIX | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	13,686	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	13,686	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)	13,686	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	108	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	19,438,479	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)	19,438,479	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)	19,438,479	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)	1,420.32	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	153,395	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)	153,395	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-2014 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-1 | Date/Time Prepared: 4/28/2023 10:34 am

Title XIX | Hospital | PPS

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	69,262	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)	222,657	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)	9,441	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	5,696	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	15,137	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	207,520	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
55.01	Permanent adjustment amount per discharge	0.00	55.01
55.02	Adjustment amount per discharge (contractor use only)	0.00	55.02
56.00	Target amount (line 54 x sum of lines 55, 55.01, and 55.02)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)	0.00	59.00
60.00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)	0.00	60.00
61.00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-2014 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-1 | Date/Time Prepared: 4/28/2023 10:34 am

Title XIX | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	1,196,475	19,438,479	0.061552	0	0	90.00
91.00	Nursing Program cost	0	19,438,479	0.000000	0	0	91.00
92.00	Allied health cost	0	19,438,479	0.000000	0	0	92.00
93.00	All other Medical Education	0	19,438,479	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-2014 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-3 | Date/Time Prepared: 4/28/2023 10:34 am

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		15,158,459		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.697134	145,277	101,278	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.310513	676,055	209,924	54.00
60.00	06000	LABORATORY	0.100490	2,845,714	285,966	60.00
65.00	06500	RESPIRATORY THERAPY	0.038707	20,155,143	780,145	65.00
66.00	06600	PHYSICAL THERAPY	0.197673	1,087,944	215,057	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.220430	923,888	203,653	67.00
68.00	06800	SPEECH PATHOLOGY	0.170981	994,639	170,064	68.00
69.00	06900	ELECTROCARDIOLOGY	0.003271	3,445,157	11,269	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.278566	3,632,565	1,011,909	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.252456	3,079,309	777,390	73.00
74.00	07400	RENAL DIALYSIS	0.297882	762,016	226,991	74.00
76.00	03950	WOUND CARE	0.000000	0	0	76.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		37,747,707	3,993,646	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)		37,747,707		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-2014 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-3 | Date/Time Prepared: 4/28/2023 10:34 am

Title XIX | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		285,101		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.697134	5,579	3,889	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.310513	13,029	4,046	54.00
60.00	06000	LABORATORY	0.100490	35,893	3,607	60.00
65.00	06500	RESPIRATORY THERAPY	0.038707	625,569	24,214	65.00
66.00	06600	PHYSICAL THERAPY	0.197673	13,122	2,594	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.220430	13,341	2,941	67.00
68.00	06800	SPEECH PATHOLOGY	0.170981	11,076	1,894	68.00
69.00	06900	ELECTROCARDIOLOGY	0.003271	63,049	206	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.278566	35,163	9,795	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.252456	63,679	16,076	73.00
74.00	07400	RENAL DIALYSIS	0.297882	0	0	74.00
76.00	03950	WOUND CARE	0.000000	0	0	76.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		879,500	69,262	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)		879,500		202.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-2014 | Period: From 01/01/2022 To 12/31/2022 | Worksheet E-1 Part I | Date/Time Prepared: 4/28/2023 10:34 am

Title XVIII | Hospital | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		11,448,436		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	04/26/2022	1,613,008		0	3.50
3.51		12/08/2022	560,282		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)		-2,173,290		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)		9,275,146		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		761,384		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		10,036,530		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	Provider CCN: 15-2014	Period: From 01/01/2022 To 12/31/2022	Worksheet E-3 Part IV Date/Time Prepared: 4/28/2023 10:34 am
	Title XVIII	Hospital	PPS

		1.00	
	PART IV - MEDICARE PART A SERVICES - LTCH PPS		
1.00	Net Federal PPS Payments (see instructions)	9,286,292	1.00
1.01	Full standard payment amount	7,680,096	1.01
1.02	Short stay outlier standard payment amount	1,606,196	1.02
1.03	Site neutral payment amount - Cost	0	1.03
1.04	Site neutral payment amount - IPPS comparable	0	1.04
2.00	Outlier Payments	1,446,390	2.00
3.00	Total PPS Payments (sum of lines 1 and 2)	10,732,682	3.00
4.00	Nursing and Allied Health Managed Care payments (see instructions)	0	4.00
5.00	Organ acquisition (DO NOT USE THIS LINE)		5.00
6.00	Cost of physicians' services in a teaching hospital (see instructions)	0	6.00
7.00	Subtotal (see instructions)	10,732,682	7.00
8.00	Primary payer payments	6,051	8.00
9.00	Subtotal (line 7 less line 8).	10,726,631	9.00
10.00	Deductibles	15,560	10.00
11.00	Subtotal (line 9 minus line 10)	10,711,071	11.00
12.00	Coinsurance	679,581	12.00
13.00	Subtotal (line 11 minus line 12)	10,031,490	13.00
14.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	204,792	14.00
15.00	Adjusted reimbursable bad debts (see instructions)	133,115	15.00
16.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	165,642	16.00
17.00	Subtotal (sum of lines 13 and 15)	10,164,605	17.00
18.00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	18.00
19.00	Other pass through costs (see instructions)	0	19.00
20.00	Outlier payments reconciliation	0	20.00
21.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	21.00
21.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	21.50
21.98	Recovery of accelerated depreciation.	0	21.98
21.99	Demonstration payment adjustment amount before sequestration	0	21.99
22.00	Total amount payable to the provider (see instructions)	10,164,605	22.00
22.01	Sequestration adjustment (see instructions)	128,075	22.01
22.02	Demonstration payment adjustment amount after sequestration	0	22.02
23.00	Interim payments	9,275,146	23.00
24.00	Tentative settlement (for contractor use only)	0	24.00
25.00	Balance due provider/program (line 22 minus lines 22.01, 22.02, 23 and 24)	761,384	25.00
26.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	26.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Wkst. E-3, Pt IV, line 2 (see instructions)	1,446,390	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money (see instructions)	0.00	52.00
53.00	Time Value of Money (see instructions)	0	53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-2014	Period: From 01/01/2022 To 12/31/2022	Worksheet E-3 Part VII Date/Time Prepared: 4/28/2023 10:34 am
	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		0	2.00
3.00	Organ acquisition (certified transplant programs only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	0	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	0	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	285,101		8.00
9.00	Ancillary service charges	879,500	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	1,164,601	0	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	1,164,601	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	1,164,601	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	0	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	0	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	0	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	0	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	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

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 15-2014 | Period: From 01/01/2022 To 12/31/2022 | Worksheet G | Date/Time Prepared: 4/28/2023 10:34 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	0	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	5,758,365	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	0	0	0	0	7.00
8.00	Prepaid expenses	67,387	0	0	0	8.00
9.00	Other current assets	218,658	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)	6,044,410	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	70,780	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	-53,530	0	0	0	14.00
15.00	Buildings	2,825,194	0	0	0	15.00
16.00	Accumulated depreciation	-1,516,766	0	0	0	16.00
17.00	Leasehold improvements	1,500,533	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	8,313,078	0	0	0	23.00
24.00	Accumulated depreciation	-6,481,965	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	4,657,324	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	2,930,935	0	0	0	32.00
33.00	Due from owners/officers	-19,026,763	0	0	0	33.00
34.00	Other assets	20,780	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	-16,075,048	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	-5,373,314	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1,916,596	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,341,099	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	0	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	3,257,695	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	2,373,293	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	2,373,293	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	5,630,988	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	-11,004,302				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)	-11,004,302	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	-5,373,314	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-2014 | Period: From 01/01/2022 To 12/31/2022 | Worksheet G-1 | Date/Time Prepared: 4/28/2023 10:34 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		-8,274,793		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-6,531,523				2.00
3.00	Total (sum of line 1 and line 2)		-14,806,316		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00	FUND BALANCE RECON	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)		-14,806,316		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)		-14,806,316		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	FUND BALANCE RECON		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: 15-2014 | Period: From 01/01/2022 To 12/31/2022 | Worksheet G-2 Parts I & II Date/Time Prepared: 4/28/2023 10:34 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	36,281,965		36,281,965	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	36,281,965		36,281,965	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	36,281,965		36,281,965	17.00
18.00	Ancillary services	90,970,050	0	90,970,050	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	127,252,015	0	127,252,015	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		28,278,636		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00	ACCT 62100 BAD DEBT	257,520			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)		257,520		36.00
37.00	**DEDUCT BAD DEBT EXPENSE**	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		28,536,156		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 15-2014	Period: From 01/01/2022 To 12/31/2022	Worksheet G-3 Date/Time Prepared: 4/28/2023 10:34 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	127,252,015	1.00
2.00	Less contractual allowances and discounts on patients' accounts	105,434,065	2.00
3.00	Net patient revenues (line 1 minus line 2)	21,817,950	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	28,536,156	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-6,718,206	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	18,794	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	1,217	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 REVENUE	1,661	24.00
24.01	PHYSICIAN REVENUE	1,708,588	24.01
24.02	BAD DEBT SETTLEMENT	0	24.02
24.50	COVID-19 PHE Funding	96,994	24.50
25.00	Total other income (sum of lines 6-24)	1,827,254	25.00
26.00	Total (line 5 plus line 25)	-4,890,952	26.00
27.00	MANAGEMENT FEE	1,255,824	27.00
27.01	INTERCOMPANY INTEREST	-8,989	27.01
27.02	TAXES	-120,983	27.02
27.03	INTEREST EXPENSE	514,719	27.03
28.00	Total other expenses (sum of line 27 and subscripts)	1,640,571	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-6,531,523	29.00