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: 15-0059	Period: From 01/01/2022 To 12/31/2022	Worksheet S Parts I-III Date/Time Prepared: 5/25/2023 3:52 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 5/25/2023 Time: 3:52 pm
2. [ ] Manually prepared cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no.

Contractor use only

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

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

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by RIVERVIEW HOSPITAL (15-0059) 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	Jayna Friend		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	Jayna Friend			2
3	Signatory Title	CFO			3
4	Date	(Dated when report is electronica			4

		Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	HOSPITAL	0	566,751	16,323	0	-188,607	1.00
2.00	SUBPROVIDER - IPF	0	0	0		0	2.00
3.00	SUBPROVIDER - IRF	0	50,092	28		-437,927	3.00
5.00	SWING BED - SNF	0	0	0		0	5.00
6.00	SWING BED - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7.00
200.00	TOTAL	0	616,843	16,351	0	-626,534	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: 15-0059 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-2 Part I | Date/Time Prepared: 5/25/2023 3:52 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 395 WESTFIELD ROAD	PO Box:			1.00
2.00	City: NOBLESVILLE	State: IN	Zip Code: 46060-	County: HAMILTON	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	RIVERVIEW HOSPITAL	150059	26900	1	07/07/1966	N	P	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF	RIVERVIEW HOSPITAL REHAB	15T059	26900	5	01/01/1994	N	P	O	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)	9		21.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0059 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-2 Part I | Date/Time Prepared: 5/25/2023 3:52 pm

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	626	347	0	0	2,409	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.	10	60	0	0	338		25.00

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0059 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-2 Part I | Date/Time Prepared: 5/25/2023 3:52 pm

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

		NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
		1.00	2.00	3.00	
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.	Y	Y		60.00
60.01	If line 60 is yes, complete columns 2 and 3 for each program. (see instructions)		23.00	1	60.01

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0059	Period: From 01/01/2022 To 12/31/2022	Worksheet S-2 Part I Date/Time Prepared: 5/25/2023 3:52 pm

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

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

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					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.		Y			75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)		N	N	0	76.00
				1.00		
	Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.			N		80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.			N		81.00
	TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.			N		85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.					86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.			N		87.00
			Approved for Permanent Adjustment (Y/N)	Number of Approved Permanent Adjustments		
			1.00	2.00		
88.00	Column 1: Is this hospital approved for a permanent adjustment to the TEFRA target amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete col. 2 and line 89. (see instructions) Column 2: Enter the number of approved permanent adjustments.			0		88.00
		Wkst. A Line No.	Effective Date	Approved Permanent Adjustment Amount Per Discharge		
		1.00	2.00	3.00		
89.00	Column 1: If line 88, column 1 is Y, enter the Worksheet A line number on which the per discharge permanent adjustment approval was based. Column 2: Enter the effective date (i.e., the cost reporting period beginning date) for the permanent adjustment to the TEFRA target amount per discharge. Column 3: Enter the amount of the approved permanent adjustment to the TEFRA target amount per discharge.	0.00		0		89.00
			V	XIX		
			1.00	2.00		
	Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.		N	Y		90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.		N	Y		91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			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

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0059 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-2 Part I | Date/Time Prepared: 5/25/2023 3:52 pm

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	848,523	0	0	118.01

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

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

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

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

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

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

				1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act				
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.			Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)				168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)				168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)			9.99	169.00
		Beginning	Ending		
		1.00	2.00		
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)				170.00
		1.00	2.00		
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N	0		171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-0059 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-2 Part II | Date/Time Prepared: 5/25/2023 3:52 pm

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

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

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

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	N		N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	04/09/2023	Y	04/09/2023	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-0059 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-2 Part II Date/Time Prepared: 5/25/2023 3:52 pm

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

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

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

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	TINA	SEVERS	41.00
42.00	Enter the employer/company name of the cost report preparer.	BLUE & CO., LLC		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-713-7946	TSEVERS@BLUEANDCO.COM	43.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-0059 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-3 Part I | Date/Time Prepared: 5/25/2023 3:52 pm

	Component	Worksheet A Line No.	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	106	38,690	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)		106	38,690	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	15	5,475	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		121	44,165	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	41.00	14	5,110		0	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	44.00	0	0		0	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		135				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: 15-0059 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-3 Part I | Date/Time Prepared: 5/25/2023 3:52 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	3,873	466	12,716			1.00
2.00	HMO and other (see instructions)	3,835	2,642				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	683	398				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)	3,873	466	12,716			7.00
8.00	INTENSIVE CARE UNIT	878	0	3,181			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		141	1,518			13.00
14.00	Total (see instructions)	4,751	607	17,415	0.00	1,012.80	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	2,096	10	3,987	0.00	16.04	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	0	0	0	0.00	0.00	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			70			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	1,028.84	27.00
28.00	Observation Bed Days		0	2,697			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	133	271			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: 15-0059 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-3 Part I | Date/Time Prepared: 5/25/2023 3:52 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	968	82	4,309	1.00
2.00	HMO and other (see instructions)			664	605		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				33		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	968	82	4,309	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	0.00	0	189	1	344	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	0.00					19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care						34.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0059 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-3 Part II Date/Time Prepared: 5/25/2023 3:52 pm

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	93,594,978	108,770	93,703,748	2,139,985.00	43.79	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)		29,251,315	436,959	29,688,274	504,955.50	58.79	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		6,369,950	0	6,369,950	46,283.97	137.63	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		494,312	0	494,312	2,368.00	208.75	13.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00	14.00
14.01	Home office salaries		0	0	0	0.00	0.00	14.01
14.02	Related organization salaries		0	0	0	0.00	0.00	14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00	16.01
16.02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.02
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		13,143,235	0	13,143,235			17.00
18.00	Wage-related costs (other) (see instructions)							18.00
19.00	Excluded areas		4,932,987	0	4,932,987			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)		0	0	0			25.50
25.51	Related organization wage-related (core)		0	0	0			25.51
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0			25.52

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0059 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-3 Part II Date/Time Prepared: 5/25/2023 3:52 pm

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.53	Home office: Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	622,650	0	622,650	15,828.00	39.34	26.00
27.00	Administrative & General	5.00	7,528,708	-219,036	7,309,672	265,247.50	27.56	27.00
28.00	Administrative & General under contract (see inst.)		217,901	0	217,901	1,068.79	203.88	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	2,357,346	0	2,357,346	69,111.00	34.11	30.00
31.00	Laundry & Linen Service	8.00	82,569	0	82,569	4,572.00	18.06	31.00
32.00	Housekeeping	9.00	1,181,088	0	1,181,088	55,093.50	21.44	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	1,299,416	-961,328	338,088	15,919.75	21.24	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	805,780	805,780	37,943.00	21.24	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	552,063	0	552,063	11,693.50	47.21	38.00
39.00	Central Services and Supply	14.00	777,394	0	777,394	27,778.50	27.99	39.00
40.00	Pharmacy	15.00	2,700,041	-281,411	2,418,630	57,502.50	42.06	40.00
41.00	Medical Records & Medical Records Library	16.00	796,689	0	796,689	29,041.75	27.43	41.00
42.00	Social Service	17.00	714,588	0	714,588	17,054.75	41.90	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0059 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-3 Part III Date/Time Prepared: 5/25/2023 3:52 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		93,812,879	108,770	93,921,649	2,141,053.79	43.87	1.00
2.00	Excluded area salaries (see instructions)		29,251,315	436,959	29,688,274	504,955.50	58.79	2.00
3.00	Subtotal salaries (line 1 minus line 2)		64,561,564	-328,189	64,233,375	1,636,098.29	39.26	3.00
4.00	Subtotal other wages & related costs (see inst.)		6,864,262	0	6,864,262	48,651.97	141.09	4.00
5.00	Subtotal wage-related costs (see inst.)		13,143,235	0	13,143,235	0.00	20.46	5.00
6.00	Total (sum of lines 3 thru 5)		84,569,061	-328,189	84,240,872	1,684,750.26	50.00	6.00
7.00	Total overhead cost (see instructions)		18,830,453	-655,995	18,174,458	607,854.54	29.90	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 15-0059 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-3 Part IV Date/Time Prepared: 5/25/2023 3:52 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	1,738,586	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)	9,043,212	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	220,481	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	34,399	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)	277,007	14.00
15.00	'Workers' Compensation Insurance	256,784	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	6,483,358	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	-12,000	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	34,395	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	18,076,222	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 15-0059 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-3 Part V | Date/Time Prepared: 5/25/2023 3:52 pm

	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	6,369,950	18,076,222	1.00
2.00	Hospital	6,369,950	18,076,222	2.00
3.00	SUBPROVIDER - IPF			3.00
4.00	SUBPROVIDER - IRF	0	0	4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	SKILLED NURSING FACILITY	0	0	8.00
9.00	NURSING FACILITY			9.00
10.00	OTHER LONG TERM CARE I			10.00
11.00	Hospital-Based HHA			11.00
12.00	AMBULATORY SURGICAL CENTER (D.P.) I			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	RENAL DIALYSIS I	0	0	17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 15-0059	Period: From 01/01/2022 To 12/31/2022	Worksheet S-10 Date/Time Prepared: 5/25/2023 3:52 pm

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.275428	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	7,396,733	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	Y	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	76,793,628	6.00
7.00	Medicaid cost (line 1 times line 6)	21,151,115	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	13,754,382	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	13,754,382	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	6,271,136	1,093,409	7,364,545	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	1,727,246	1,093,409	2,820,655	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	1,727,246	1,093,409	2,820,655	23.00

		1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	16,808,671	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	42,913	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	66,020	27.01
28.00	Non-Medicare bad debt expense (see instructions)	16,742,651	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	4,634,502	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	7,455,157	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	21,209,539	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0059 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A | Date/Time Prepared: 5/25/2023 3:52 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		21,779,438	21,779,438	-491,778	21,287,660	1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	622,650	8,178,228	8,800,878	866,851	9,667,729	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	7,528,708	40,836,501	48,365,209	491,778	48,856,987	5.00
7.00	00700	OPERATION OF PLANT	2,357,346	7,088,116	9,445,462	0	9,445,462	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	82,569	1,422,453	1,505,022	0	1,505,022	8.00
9.00	00900	HOUSEKEEPING	1,181,088	1,152,351	2,333,439	0	2,333,439	9.00
10.00	01000	DIETARY	1,299,416	2,159,183	3,458,599	-2,564,350	894,249	10.00
11.00	01100	CAFETERIA	0	0	0	2,144,710	2,144,710	11.00
13.00	01300	NURSING ADMINISTRATION	552,063	89,201	641,264	0	641,264	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	777,394	198,632	976,026	7,732,554	8,708,580	14.00
15.00	01500	PHARMACY	2,700,041	19,223,576	21,923,617	-309,411	21,614,206	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	796,689	535,278	1,331,967	0	1,331,967	16.00
17.00	01700	SOCIAL SERVICE	714,588	239,708	954,296	0	954,296	17.00
23.00	02300	PARAMED ED PRGM PHARMACY	0	0	0	296,162	296,162	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	10,774,051	3,335,614	14,109,665	-593,951	13,515,714	30.00
31.00	03100	INTENSIVE CARE UNIT	2,975,944	1,546,095	4,522,039	-244,451	4,277,588	31.00
41.00	04100	SUBPROVIDER - IRF	1,528,814	1,033,048	2,561,862	-71,884	2,489,978	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,582,059	10,221,921	14,803,980	-4,176,932	10,627,048	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,219,802	774,370	2,994,172	-10,251	2,983,921	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	508,954	593,293	1,102,247	845	1,103,092	55.00
57.00	05700	CT SCAN	469,787	221,857	691,644	-111,080	580,564	57.00
57.01	03630	ULTRA SOUND	448,660	50,752	499,412	-6,091	493,321	57.01
58.00	05800	MRI	332,689	48,647	381,336	-6,899	374,437	58.00
59.00	05900	CARDIAC CATHETERIZATION	927,536	1,598,807	2,526,343	-740,899	1,785,444	59.00
60.00	06000	LABORATORY	3,392,101	6,825,224	10,217,325	-2,913	10,214,412	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	533,314	533,314	0	533,314	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,654,638	651,830	2,306,468	-128,711	2,177,757	65.00
66.00	06600	PHYSICAL THERAPY	5,127,607	1,513,946	6,641,553	-7,091	6,634,462	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	602,834	187,190	790,024	-213	789,811	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	9,491,902	9,491,902	0	9,491,902	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	355,633	355,633	-2,082	353,551	74.00
76.00	03020	OTHER ANCILLARY	0	0	0	0	0	76.00
76.01	03140	CARDIAC REHAB	796,262	350,619	1,146,881	-136,528	1,010,353	76.01
76.02	03070	WOMEN'S CENTER	477,213	164,637	641,850	-73,684	568,166	76.02
76.03	03330	ENDOSCOPY	0	0	0	0	0	76.03
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	377,203	187,318	564,521	-35,589	528,932	90.00
90.01	09001	OUTPATIENT	606,534	843,803	1,450,337	-292,455	1,157,882	90.01
90.02	09002	NEUROPSYCHOLOGY	398,572	131,703	530,275	0	530,275	90.02
91.00	09100	EMERGENCY	9,058,665	23,020,739	32,079,404	-1,364,733	30,714,671	91.00
91.01	09101	SHORT STAY	0	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	41,802	34,043	75,845	0	75,845	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	65,914,279	166,618,970	232,533,249	160,924	232,694,173	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	118,547	133,541	252,088	0	252,088	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	21,987,162	10,962,616	32,949,778	-572,445	32,377,333	192.00
192.01	19201	FOUNDATION	192,673	23,445	216,118	0	216,118	192.01
192.02	19202	CLINICS	972,896	202,946	1,175,842	-742	1,175,100	192.02
192.03	19206	HOME HEALTH PARTNERSHIP	0	1,617	1,617	0	1,617	192.03
192.04	19207	WESTFIELD SCHOOLS	1,192,253	169,076	1,361,329	-467	1,360,862	192.04
192.05	19203	PRACTICE MANAGEMENT	411,136	672,921	1,084,057	0	1,084,057	192.05
192.06	19204	MOB - NOBLESVILLE SQUARE	0	59,166	59,166	0	59,166	192.06
192.07	19208	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.07
192.08	19205	RIVERVIEW MEDICAL ARTS	0	151,554	151,554	0	151,554	192.08
192.09	19209	BEHAVIOR CARE	503,969	182,852	686,821	0	686,821	192.09

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0059 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A | Date/Time Prepared: 5/25/2023 3:52 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	PHYSICIAN SERVICES-LYONS	0	267	267	0	267	193.01
193.02	19302	UNIVERSITY HS ATHLETICS	47,634	4,921	52,555	0	52,555	193.02
193.03	19303	OB/GYN SPEC NEMUNAITI	520,739	81,363	602,102	0	602,102	193.03
193.04	19304	OB/GYN SPEC GATHERS	117,491	22,409	139,900	0	139,900	193.04
193.05	19305	OB SPECIALISTS DAVENPORT	768,142	103,190	871,332	0	871,332	193.05
193.06	19306	OUTPATIENT PHARMACY	576,634	4,266,395	4,843,029	-72	4,842,957	193.06
194.00	07950	WORKMED	271,423	283,566	554,989	-1,214	553,775	194.00
194.01	07951	MEALS ON WHEELS	0	0	0	414,016	414,016	194.01
200.00		TOTAL (SUM OF LINES 118 through 199)	93,594,978	183,940,815	277,535,793	0	277,535,793	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0059 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A | Date/Time Prepared: 5/25/2023 3:52 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	-31,742	21,255,918		1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-53,824	9,613,905		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-20,421,895	28,435,092		5.00
7.00	00700	OPERATION OF PLANT	0	9,445,462		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	1,505,022		8.00
9.00	00900	HOUSEKEEPING	0	2,333,439		9.00
10.00	01000	DIETARY	-108,685	785,564		10.00
11.00	01100	CAFETERIA	-703,990	1,440,720		11.00
13.00	01300	NURSING ADMINISTRATION	0	641,264		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	59	8,708,639		14.00
15.00	01500	PHARMACY	0	21,614,206		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-1,411	1,330,556		16.00
17.00	01700	SOCIAL SERVICE	0	954,296		17.00
23.00	02300	PARAMED ED PRGM PHARMACY	0	296,162		23.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	13,515,714		30.00
31.00	03100	INTENSIVE CARE UNIT	0	4,277,588		31.00
41.00	04100	SUBPROVIDER - IRF	0	2,489,978		41.00
43.00	04300	NURSERY	0	0		43.00
44.00	04400	SKILLED NURSING FACILITY	0	0		44.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-2,527,767	8,099,281		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-3,153	2,980,768		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	1,103,092		55.00
57.00	05700	CT SCAN	-2,891	577,673		57.00
57.01	03630	ULTRA SOUND	-316	493,005		57.01
58.00	05800	MRI	0	374,437		58.00
59.00	05900	CARDIAC CATHETERIZATION	-735,000	1,050,444		59.00
60.00	06000	LABORATORY	-91,455	10,122,957		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	533,314		63.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	2,177,757		65.00
66.00	06600	PHYSICAL THERAPY	-78,489	6,555,973		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	-105,604	684,207		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	9,491,902		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
74.00	07400	RENAL DIALYSIS	0	353,551		74.00
76.00	03020	OTHER ANCILLARY	0	0		76.00
76.01	03140	CARDIAC REHAB	-686	1,009,667		76.01
76.02	03070	WOMEN'S CENTER	0	568,166		76.02
76.03	03330	ENDOSCOPY	0	0		76.03
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0		77.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	528,932		90.00
90.01	09001	OUTPATIENT	-14,311	1,143,571		90.01
90.02	09002	NEUROPSYCHOLOGY	-265,019	265,256		90.02
91.00	09100	EMERGENCY	-13,393,409	17,321,262		91.00
91.01	09101	SHORT STAY	0	0		91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	-125	75,720		95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0		102.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-38,539,713	194,154,460		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	252,088		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	32,377,333		192.00
192.01	19201	FOUNDATION	0	216,118		192.01
192.02	19202	CLINICS	0	1,175,100		192.02
192.03	19206	HOME HEALTH PARTNERSHIP	0	1,617		192.03
192.04	19207	WESTFIELD SCHOOLS	0	1,360,862		192.04
192.05	19203	PRACTICE MANAGEMENT	0	1,084,057		192.05
192.06	19204	MOB - NOBLESVILLE SQUARE	0	59,166		192.06
192.07	19208	PHYSICIANS' PRIVATE OFFICES	0	0		192.07
192.08	19205	RIVERVIEW MEDICAL ARTS	0	151,554		192.08
192.09	19209	BEHAVIOR CARE	0	686,821		192.09
193.00	19300	NONPAID WORKERS	0	0		193.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0059 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A | Date/Time Prepared: 5/25/2023 3:52 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
193.01	19301	PHYSICIAN SERVICES-LYONS	0	267		193.01
193.02	19302	UNIVERSITY HS ATHLETICS	0	52,555		193.02
193.03	19303	OB/GYN SPEC NEMUNAITI	0	602,102		193.03
193.04	19304	OB/GYN SPEC GATHERS	0	139,900		193.04
193.05	19305	OB SPECIALISTS DAVENPORT	0	871,332		193.05
193.06	19306	OUTPATIENT PHARMACY	0	4,842,957		193.06
194.00	07950	WORKMED	0	553,775		194.00
194.01	07951	MEALS ON WHEELS	0	414,016		194.01
200.00		TOTAL (SUM OF LINES 118 through 199)	-38,539,713	238,996,080		200.00

RECLASSIFICATIONS | Provider CCN: 15-0059 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-6 | Date/Time Prepared: 5/25/2023 3:52 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - CAFETERIA RECLASS				
1.00	CAFETERIA	11.00	805,780	1,338,930	1.00
	TOTALS		805,780	1,338,930	
	B - MEALS ON WHEELS RECLASS				
1.00	MEALS ON WHEELS	194.01	155,548	258,468	1.00
	TOTALS		155,548	258,468	
	C - INSURANCE RECLASS				
1.00	ADMINISTRATIVE & GENERAL	5.00		491,778	1.00
	TOTALS		0	491,778	
	D - MEDICAL SUPPLY RECLASS				
1.00	CENTRAL SERVICES & SUPPLY	14.00		7,732,554	1.00
2.00	RADIOLOGY-THERAPEUTIC	55.00		845	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
26.00		0.00	0	0	26.00
27.00		0.00	0	0	27.00
	TOTALS		0	7,733,399	
	E - RSMA RECLASS				
1.00	OPERATING ROOM	50.00	327,806		1.00
2.00	EMPLOYEE BENEFITS DEPARTMENT	4.00		10,228	2.00
	TOTALS		327,806	10,228	
	F - PARAMED ED RECLASS				
1.00	PARAMED ED PRGM PHARMACY	23.00	281,411	14,751	1.00
	TOTALS		281,411	14,751	
	G - COMMUNITY RELATIONS RECLASS				
1.00	ADMINISTRATIVE & GENERAL	5.00		219,036	1.00
	TOTALS		0	219,036	
	H - ALLOCATED BENEFITS RECLASS				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	857,588	1.00
	TOTALS		0	857,588	
500.00	Grand Total: Increases		1,570,545	10,924,178	500.00

RECLASSIFICATIONS | Provider CCN: 15-0059 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-6 | Date/Time Prepared: 5/25/2023 3:52 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - CAFETERIA RECLASS						
1.00	DIETARY	10.00	805,780	1,338,930	0		1.00
	TOTALS		805,780	1,338,930			
	B - MEALS ON WHEELS RECLASS						
1.00	DIETARY	10.00	155,548	258,468	0		1.00
	TOTALS		155,548	258,468			
	C - INSURANCE RECLASS						
1.00	CAP REL COSTS-BLDG & FIXT	1.00		491,778	12		1.00
	TOTALS		0	491,778			
	D - MEDICAL SUPPLY RECLASS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00		965	0		1.00
2.00	DIETARY	10.00		5,624	0		2.00
3.00	PHARMACY	15.00		13,249	0		3.00
4.00	ADULTS & PEDIATRICS	30.00		593,951	0		4.00
5.00	INTENSIVE CARE UNIT	31.00		244,451	0		5.00
6.00	SUBPROVIDER - IRF	41.00		71,884	0		6.00
7.00	OPERATING ROOM	50.00		4,166,704	0		7.00
8.00	RADIOLOGY-DIAGNOSTIC	54.00		10,251	0		8.00
9.00	CT SCAN	57.00		111,080	0		9.00
10.00	ULTRA SOUND	57.01		6,091	0		10.00
11.00	MRI	58.00		6,899	0		11.00
12.00	CARDIAC CATHETERIZATION	59.00		740,899	0		12.00
13.00	LABORATORY	60.00		2,913	0		13.00
14.00	RESPIRATORY THERAPY	65.00		128,711	0		14.00
15.00	PHYSICAL THERAPY	66.00		7,091	0		15.00
16.00	ELECTROCARDIOLOGY	69.00		213	0		16.00
17.00	RENAL DIALYSIS	74.00		2,082	0		17.00
18.00	CARDIAC REHAB	76.01		136,528	0		18.00
19.00	WOMEN'S CENTER	76.02		73,684	0		19.00
20.00	CLINIC	90.00		35,589	0		20.00
21.00	OUTPATIENT	90.01		292,455	0		21.00
22.00	EMERGENCY	91.00		507,145	0		22.00
23.00	PHYSICIANS' PRIVATE OFFICES	192.00		572,445	0		23.00
24.00	CLINICS	192.02		742	0		24.00
25.00	WESTFIELD SCHOOLS	192.04		467	0		25.00
26.00	OUTPATIENT PHARMACY	193.06		72	0		26.00
27.00	WORKMED	194.00		1,214	0		27.00
	TOTALS		0	7,733,399			
	E - RSMA RECLASS						
1.00	OPERATING ROOM	50.00		338,034	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		0	338,034			
	F - PARAMED ED RECLASS						
1.00	PHARMACY	15.00	281,411	14,751	0		1.00
	TOTALS		281,411	14,751			
	G - COMMUNITY RELATIONS RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	219,036		0		1.00
	TOTALS		219,036	0			
	H - ALLOCATED BENEFITS RECLASS						
1.00	EMERGENCY	91.00	0	857,588	0		1.00
	TOTALS		0	857,588			
500.00	Grand Total: Decreases		1,461,775	11,032,948			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0059 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-7 Part I | Date/Time Prepared: 5/25/2023 3:52 pm

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	16,050,414	0	0	0	0	1.00
2.00	Land Improvements	3,231,090	99,218	0	99,218	0	2.00
3.00	Buildings and Fixtures	166,173,303	513,468	0	513,468	0	3.00
4.00	Building Improvements	1,399,855	17,434,328	0	17,434,328	0	4.00
5.00	Fixed Equipment	50,300,481	2,383,386	0	2,383,386	0	5.00
6.00	Movable Equipment	122,055,242	3,588,268	0	3,588,268	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	359,210,385	24,018,668	0	24,018,668	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	359,210,385	24,018,668	0	24,018,668	0	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	16,050,414	0	1.00
2.00	Land Improvements	3,330,308	0	2.00
3.00	Buildings and Fixtures	166,686,771	0	3.00
4.00	Building Improvements	18,834,183	0	4.00
5.00	Fixed Equipment	52,683,867	0	5.00
6.00	Movable Equipment	125,643,510	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	383,229,053	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	383,229,053	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0059 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-7 Part II | Date/Time Prepared: 5/25/2023 3:52 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	21,779,438	0	0	0	0	1.00
3.00	Total (sum of lines 1-2)	21,779,438	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL			
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)		
		14.00	15.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2				
1.00	CAP REL COSTS-BLDG & FIXT	0	21,779,438		1.00
3.00	Total (sum of lines 1-2)	0	21,779,438		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0059 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-7 Part III Date/Time Prepared: 5/25/2023 3:52 pm

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	383,229,053	0	383,229,053	1.000000	0	1.00
3.00	Total (sum of lines 1-2)	383,229,053	0	383,229,053	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	21,779,438	0	1.00
3.00	Total (sum of lines 1-2)	0	0	0	21,779,438	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	-31,742	-491,778	0	0	21,255,918	1.00
3.00	Total (sum of lines 1-2)	-31,742	-491,778	0	0	21,255,918	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0059 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-8 | Date/Time Prepared: 5/25/2023 3:52 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	*** Cost Center Deleted ***	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-20,357,046			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	254,925			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-476,914	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	*** Cost Center Deleted ***	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0059 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-8 | Date/Time Prepared: 5/25/2023 3:52 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	HAF EXPENSE	A	-14,549,852	ADMINISTRATIVE & GENERAL	5.00	0	33.00
33.01	ADMINISTRATION RECRUITMENT/SPECIAL E	A	-8,987	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02	OTHER REV MEDICAL REPORT	B	-1,411	MEDICAL RECORDS & LIBRARY	16.00	0	33.02
33.03	OTHER REVENUES ->PURCHASE DISCOUNTS	B	-12,356	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04	RADIOLOGY- OTHER REVENUE-CDS FOR LEG	B	-3,153	RADIOLOGY-DIAGNOSTIC	54.00	0	33.04
33.05	AMBULANCE OTHER REVENUE	B	-125	AMBULANCE SERVICES	95.00	0	33.05
33.06	LABORATORY -> OTHER REVENUE	B	-91,455	LABORATORY	60.00	0	33.06
33.07	MATERNITY CENER OTHER REVNEU	B	0	OPERATION OF PLANT	7.00	0	33.07
33.08	INFORMATION SYSTEMS OTHER REV	B	0	WOMEN'S CENTER	76.02	0	33.08
33.09	ADMINISTRATION LEAN TEAM	B	0	EMERGENCY	91.00	0	33.09
33.10	EDUCATION -> OTHER REVENUE	B	-16,263	ADMINISTRATIVE & GENERAL	5.00	0	33.10
33.11	OP PHARMACY REVENUE	A	0	PHARMACY	15.00	0	33.11
33.12	DIETARY SALES PR DEDUCT	B	-227,076	CAFETERIA	11.00	0	33.12
33.13	WELLNESS SERVICES - EXTERNAL->-OTHER	B	-18,512	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.13
33.14	OTHER REV PREMIER PROGRAM	B	0	CENTRAL SERVICES & SUPPLY	14.00	0	33.14
33.15	WESTFIELD BISTRO-OTHER REVENUE	B	-108,685	DIETARY	10.00	0	33.15
33.16	NON-OP REV -> MISCELLANEOUS INTEREST	B	-31,742	CAP REL COSTS-BLDG & FIXT	1.00	11	33.16
33.17	COMMUNITY RELATIONS	A	-2,097,304	ADMINISTRATIVE & GENERAL	5.00	0	33.17
33.18	COMMUNITY RELATIONS BENEFITS	A	-21,370	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.18
33.19	CRNA	A	-876,000	OPERATING ROOM	50.00	0	33.19
33.20	IHA LOBBYING EXPENSE	A	-6,395	ADMINISTRATIVE & GENERAL	5.00	0	33.20
33.21	CV SERVICES-OTHER REVENUE	B	0	ELECTROCARDIOLOGY	69.00	0	33.21
33.22	CT SCAN-OTHER REVENUE	B	-2,891	CT SCAN	57.00	0	33.22
33.23	FISCAL SERVICES COMMERCE BANK REBATE	B	-114,234	ADMINISTRATIVE & GENERAL	5.00	0	33.23
33.24	ULTRASOUND - OTHER REVENUE	B	-316	ULTRA SOUND	57.01	0	33.24
33.25	WOUND CARE-OTHER REVENUE	B	-14,311	OUTPATIENT	90.01	0	33.25
33.26	NON-OP EXPENSE INVESTMENT FEES	A	242,725	ADMINISTRATIVE & GENERAL	5.00	0	33.26
33.27	OTHER MISC REVENUE	B	-1	ADMINISTRATIVE & GENERAL	5.00	0	33.27
33.28	NEUROPSYCHOLOGY OTHER REVENUE	B	-1,023	NEUROPSYCHOLOGY	90.02	0	33.28
33.29	OTHER REV RADIOLOGY FILM	B	0	RADIOLOGY-DIAGNOSTIC	54.00	0	33.29
33.30	ADMIN DONATIONS	B	0	ADMINISTRATIVE & GENERAL	5.00	0	33.30
33.31	CENTRAL PROCESSING OTHER REVENUE	B	59	CENTRAL SERVICES & SUPPLY	14.00	0	33.31
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-38,539,713				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: 15-0059	Period: From 01/01/2022 To 12/31/2022	Worksheet A-8-1 Date/Time Prepared: 5/25/2023 3:52 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	50.00	OPERATING ROOM	OPERATING ROOM	642,205	387,280	1.00
2.00	0.00			0	0	2.00
3.00	0.00			0	0	3.00
4.00	0.00			0	0	4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			642,205	387,280	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	RSMA	51.00		0.00	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: 15-0059	Period: From 01/01/2022 To 12/31/2022	Worksheet A-8-1 Date/Time Prepared: 5/25/2023 3:52 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	254,925	0		1.00
2.00	0	0		2.00
3.00	0	0		3.00
4.00	0	0		4.00
5.00	254,925			5.00

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

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

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

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

6.00			6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-0059 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-8-2 | Date/Time Prepared: 5/25/2023 3:52 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	13,942	13,942	0	0	0	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	3,859,228	3,859,228	0	0	0	2.00
3.00	50.00	OPERATING ROOM	1,906,692	1,906,692	0	0	0	3.00
4.00	59.00	CARDIAC CATHETERIZATION	735,000	735,000	0	0	0	4.00
5.00	66.00	PHYSICAL THERAPY	78,489	78,489	0	0	0	5.00
6.00	69.00	ELECTROCARDIOLOGY	105,604	105,604	0	0	0	6.00
7.00	76.01	CARDIAC REHAB	686	686	0	0	0	7.00
8.00	90.02	NEUROPSYCHOLOGY	263,996	263,996	0	0	0	8.00
9.00	91.00	EMERGENCY	13,393,409	13,393,409	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			20,357,046	20,357,046	0		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	2.00
3.00	50.00	OPERATING ROOM	0	0	0	0	0	3.00
4.00	59.00	CARDIAC CATHETERIZATION	0	0	0	0	0	4.00
5.00	66.00	PHYSICAL THERAPY	0	0	0	0	0	5.00
6.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	6.00
7.00	76.01	CARDIAC REHAB	0	0	0	0	0	7.00
8.00	90.02	NEUROPSYCHOLOGY	0	0	0	0	0	8.00
9.00	91.00	EMERGENCY	0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	13,942		1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	3,859,228		2.00
3.00	50.00	OPERATING ROOM	0	0	0	1,906,692		3.00
4.00	59.00	CARDIAC CATHETERIZATION	0	0	0	735,000		4.00
5.00	66.00	PHYSICAL THERAPY	0	0	0	78,489		5.00
6.00	69.00	ELECTROCARDIOLOGY	0	0	0	105,604		6.00
7.00	76.01	CARDIAC REHAB	0	0	0	686		7.00
8.00	90.02	NEUROPSYCHOLOGY	0	0	0	263,996		8.00
9.00	91.00	EMERGENCY	0	0	0	13,393,409		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	20,357,046		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0059 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part I | Date/Time Prepared: 5/25/2023 3:52 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
			0	1.00	4.00	4A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	21,255,918	21,255,918				1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	9,613,905	78,204	9,692,109			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	28,435,092	1,613,184	761,120	30,809,396	30,809,396	5.00
7.00	00700	OPERATION OF PLANT	9,445,462	7,194,155	245,459	16,885,076	2,498,806	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,505,022	49,301	8,597	1,562,920	231,295	8.00
9.00	00900	HOUSEKEEPING	2,333,439	39,881	122,981	2,496,301	369,425	9.00
10.00	01000	DIETARY	785,564	431,039	35,203	1,251,806	185,254	10.00
11.00	01100	CAFETERIA	1,440,720	0	83,902	1,524,622	225,627	11.00
13.00	01300	NURSING ADMINISTRATION	641,264	0	57,484	698,748	103,407	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	8,708,639	236,002	80,946	9,025,587	1,335,688	14.00
15.00	01500	PHARMACY	21,614,206	294,317	251,840	22,160,363	3,279,490	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,330,556	78,306	82,955	1,491,817	220,773	16.00
17.00	01700	SOCIAL SERVICE	954,296	55,671	74,406	1,084,373	160,475	17.00
23.00	02300	PARAMED ED PRGM PHARMACY	296,162	5,252	29,302	330,716	48,942	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	13,515,714	3,175,678	1,121,848	17,813,240	2,636,164	30.00
31.00	03100	INTENSIVE CARE UNIT	4,277,588	478,849	309,870	5,066,307	749,758	31.00
41.00	04100	SUBPROVIDER - IRF	2,489,978	506,261	159,188	3,155,427	466,968	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,099,281	1,710,194	511,240	10,320,715	1,527,352	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,980,768	450,251	231,137	3,662,156	541,959	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	1,103,092	243,152	52,995	1,399,239	207,072	55.00
57.00	05700	CT SCAN	577,673	0	48,917	626,590	92,728	57.00
57.01	03630	ULTRA SOUND	493,005	0	46,717	539,722	79,873	57.01
58.00	05800	MRI	374,437	0	34,641	409,078	60,539	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,050,444	79,966	96,580	1,226,990	181,581	59.00
60.00	06000	LABORATORY	10,122,957	491,318	353,203	10,967,478	1,623,066	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	533,314	83,694	0	617,008	91,310	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	2,177,757	49,877	172,289	2,399,923	355,162	65.00
66.00	06600	PHYSICAL THERAPY	6,555,973	159,187	533,912	7,249,072	1,072,783	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	684,207	224,854	62,770	971,831	143,820	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	9,491,902	0	0	9,491,902	1,404,697	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	353,551	31,478	0	385,029	56,980	74.00
76.00	03020	OTHER ANCILLARY	0	0	0	0	0	76.00
76.01	03140	CARDIAC REHAB	1,009,667	372,690	82,911	1,465,268	216,844	76.01
76.02	03070	WOMEN'S CENTER	568,166	312,309	49,690	930,165	137,654	76.02
76.03	03330	ENDOSCOPY	0	0	0	0	0	76.03
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	528,932	81,694	39,276	649,902	96,178	90.00
90.01	09001	OUTPATIENT	1,143,571	118,967	63,155	1,325,693	196,188	90.01
90.02	09002	NEUROPSYCHOLOGY	265,256	57,535	41,501	364,292	53,911	90.02
91.00	09100	EMERGENCY	17,321,262	718,409	943,233	18,982,904	2,809,261	91.00
91.01	09101	SHORT STAY	0	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	75,720	9,250	4,353	89,323	13,219	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	194,154,460	19,430,925	6,793,621	189,430,979	23,474,249	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	252,088	203,982	12,344	468,414	69,320	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	32,377,333	1,621,011	2,289,451	36,287,795	5,370,251	192.00
192.01	19201	FOUNDATION	216,118	0	20,062	236,180	34,952	192.01
192.02	19202	CLINICS	1,175,100	0	101,303	1,276,403	188,894	192.02
192.03	19206	HOME HEALTH PARTNERSHIP	1,617	0	0	1,617	239	192.03
192.04	19207	WESTFIELD SCHOOLS	1,360,862	0	124,143	1,485,005	219,764	192.04
192.05	19203	PRACTICE MANAGEMENT	1,084,057	0	42,810	1,126,867	166,764	192.05
192.06	19204	MOB - NOBLESVILLE SQUARE	59,166	0	0	59,166	8,756	192.06

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0059 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part I Date/Time Prepared: 5/25/2023 3:52 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
			0	1.00	4.00	4A	5.00	
192.07	19208	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.07
192.08	19205	RIVERVIEW MEDICAL ARTS	151,554	0	0	151,554	22,428	192.08
192.09	19209	BEHAVIOR CARE	686,821	0	52,476	739,297	109,408	192.09
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	PHYSICIAN SERVICES-LYONS	267	0	0	267	40	193.01
193.02	19302	UNIVERSITY HS ATHLETICS	52,555	0	4,960	57,515	8,512	193.02
193.03	19303	OB/GYN SPEC NEMUNAITI	602,102	0	54,222	656,324	97,129	193.03
193.04	19304	OB/GYN SPEC GATHERS	139,900	0	12,234	152,134	22,514	193.04
193.05	19305	OB SPECIALISTS DAVENPORT	871,332	0	79,983	951,315	140,784	193.05
193.06	19306	OUTPATIENT PHARMACY	4,842,957	0	60,042	4,902,999	725,590	193.06
194.00	07950	WORKMED	553,775	0	28,262	582,037	86,135	194.00
194.01	07951	MEALS ON WHEELS	414,016	0	16,196	430,212	63,667	194.01
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	238,996,080	21,255,918	9,692,109	238,996,080	30,809,396	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0059 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part I | Date/Time Prepared: 5/25/2023 3:52 pm

		Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	19,383,882					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	77,253	1,871,468				8.00
9.00	00900	HOUSEKEEPING	62,493	0	2,928,219			9.00
10.00	01000	DIETARY	675,420	0	309,852	2,422,332		10.00
11.00	01100	CAFETERIA	0	0	0	0	1,750,249	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	16,707	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	369,806	15,167	136,398	0	39,686	14.00
15.00	01500	PHARMACY	461,182	0	88,754	0	82,150	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	122,702	0	0	0	41,491	16.00
17.00	01700	SOCIAL SERVICE	87,235	0	17,683	0	24,366	17.00
23.00	02300	PARAMED ED PRGM PHARMACY	8,230	0	0	0	3,487	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,976,158	632,473	1,797,728	1,694,203	290,505	30.00
31.00	03100	INTENSIVE CARE UNIT	750,337	147,446	0	191,751	75,930	31.00
41.00	04100	SUBPROVIDER - IRF	793,291	157,649	0	536,378	47,657	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,679,805	195,841	63,750	0	180,649	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	705,525	118,161	110,605	0	76,752	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	381,009	16,325	0	0	18,645	55.00
57.00	05700	CT SCAN	0	0	110,605	0	15,839	57.00
57.01	03630	ULTRA SOUND	0	0	0	0	12,648	57.01
58.00	05800	MRI	0	0	110,605	0	10,878	58.00
59.00	05900	CARDIAC CATHETERIZATION	125,304	52,063	0	0	25,751	59.00
60.00	06000	LABORATORY	769,876	0	136,398	0	145,166	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	131,144	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	78,156	0	0	0	56,473	65.00
66.00	06600	PHYSICAL THERAPY	249,440	17,014	43,814	0	202,992	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	352,338	17,317	0	0	22,590	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	49,325	0	0	0	0	74.00
76.00	03020	OTHER ANCILLARY	0	0	0	0	0	76.00
76.01	03140	CARDIAC REHAB	583,991	1,489	0	0	33,037	76.01
76.02	03070	WOMEN'S CENTER	489,376	10,065	0	0	23,663	76.02
76.03	03330	ENDOSCOPY	0	0	0	0	0	76.03
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	128,012	2,730	0	0	17,485	90.00
90.01	09001	OUTPATIENT	186,416	54,820	0	0	21,613	90.01
90.02	09002	NEUROPSYCHOLOGY	90,155	0	0	0	13,836	90.02
91.00	09100	EMERGENCY	1,125,718	272,363	0	0	224,544	91.00
91.01	09101	SHORT STAY	0	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	14,495	0	0	0	2,049	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	16,524,192	1,710,923	2,926,192	2,422,332	1,726,589	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	319,631	0	2,027	0	6,522	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,540,059	159,166	0	0	0	192.00
192.01	19201	FOUNDATION	0	0	0	0	6,673	192.01
192.02	19202	CLINICS	0	717	0	0	0	192.02
192.03	19206	HOME HEALTH PARTNERSHIP	0	0	0	0	0	192.03
192.04	19207	WESTFIELD SCHOOLS	0	0	0	0	0	192.04
192.05	19203	PRACTICE MANAGEMENT	0	662	0	0	0	192.05
192.06	19204	MOB - NOBLESVILLE SQUARE	0	0	0	0	0	192.06
192.07	19208	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.07
192.08	19205	RIVERVIEW MEDICAL ARTS	0	0	0	0	0	192.08
192.09	19209	BEHAVIOR CARE	0	0	0	0	0	192.09
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	PHYSICIAN SERVICES-LYONS	0	0	0	0	0	193.01

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0059 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part I Date/Time Prepared: 5/25/2023 3:52 pm

		Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
193.02	19302	UNIVERSITY HS ATHLETICS	0	0	0	0	0	193.02
193.03	19303	OB/GYN SPEC NEMUNAITI	0	0	0	0	0	193.03
193.04	19304	OB/GYN SPEC GATHERS	0	0	0	0	0	193.04
193.05	19305	OB SPECIALISTS DAVENPORT	0	0	0	0	0	193.05
193.06	19306	OUTPATIENT PHARMACY	0	0	0	0	0	193.06
194.00	07950	WORKMED	0	0	0	0	0	194.00
194.01	07951	MEALS ON WHEELS	0	0	0	0	10,465	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	19,383,882	1,871,468	2,928,219	2,422,332	1,750,249	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0059 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part I | Date/Time Prepared: 5/25/2023 3:52 pm

		Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			13.00	14.00	15.00	16.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	818,862					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	10,922,332				14.00
15.00	01500	PHARMACY	0	0	26,071,939			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	1,876,783		16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	1,374,132	17.00
23.00	02300	PARAMED ED PRGM PHARMACY	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	372,489	0	0	1,011,513	1,187,784	30.00
31.00	03100	INTENSIVE CARE UNIT	97,357	0	0	0	84,757	31.00
41.00	04100	SUBPROVIDER - IRF	61,105	0	0	0	101,591	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
57.01	03630	ULTRA SOUND	0	0	0	0	0	57.01
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	10,922,332	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	26,071,939	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020	OTHER ANCILLARY	0	0	0	0	0	76.00
76.01	03140	CARDIAC REHAB	0	0	0	0	0	76.01
76.02	03070	WOMEN'S CENTER	0	0	0	0	0	76.02
76.03	03330	ENDOSCOPY	0	0	0	0	0	76.03
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OUTPATIENT	0	0	0	0	0	90.01
90.02	09002	NEUROPSYCHOLOGY	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	287,911	0	0	865,270	0	91.00
91.01	09101	SHORT STAY	0	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	818,862	10,922,332	26,071,939	1,876,783	1,374,132	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	FOUNDATION	0	0	0	0	0	192.01
192.02	19202	CLINICS	0	0	0	0	0	192.02
192.03	19206	HOME HEALTH PARTNERSHIP	0	0	0	0	0	192.03
192.04	19207	WESTFIELD SCHOOLS	0	0	0	0	0	192.04
192.05	19203	PRACTICE MANAGEMENT	0	0	0	0	0	192.05
192.06	19204	MOB - NOBLESVILLE SQUARE	0	0	0	0	0	192.06
192.07	19208	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.07
192.08	19205	RIVERVIEW MEDICAL ARTS	0	0	0	0	0	192.08
192.09	19209	BEHAVIOR CARE	0	0	0	0	0	192.09
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0059 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part I Date/Time Prepared: 5/25/2023 3:52 pm

		Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			13.00	14.00	15.00	16.00	17.00	
193.01	19301	PHYSICIAN SERVICES-LYONS	0	0	0	0	0	193.01
193.02	19302	UNIVERSITY HS ATHLETICS	0	0	0	0	0	193.02
193.03	19303	OB/GYN SPEC NEMUNAITI	0	0	0	0	0	193.03
193.04	19304	OB/GYN SPEC GATHERS	0	0	0	0	0	193.04
193.05	19305	OB SPECIALISTS DAVENPORT	0	0	0	0	0	193.05
193.06	19306	OUTPATIENT PHARMACY	0	0	0	0	0	193.06
194.00	07950	WORKMED	0	0	0	0	0	194.00
194.01	07951	MEALS ON WHEELS	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	818,862	10,922,332	26,071,939	1,876,783	1,374,132	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0059 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part I | Date/Time Prepared: 5/25/2023 3:52 pm

		Cost Center Description	PARAMED ED PRGM PHARMACY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			23.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
23.00	02300	PARAMED ED PRGM PHARMACY	391,375					23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	32,412,257	0	32,412,257		30.00
31.00	03100	INTENSIVE CARE UNIT	0	7,163,643	0	7,163,643		31.00
41.00	04100	SUBPROVIDER - IRF	0	5,320,066	0	5,320,066		41.00
43.00	04300	NURSERY	0	0	0	0		43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0		44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	14,968,112	0	14,968,112		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	5,215,158	0	5,215,158		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	2,022,290	0	2,022,290		55.00
57.00	05700	CT SCAN	0	845,762	0	845,762		57.00
57.01	03630	ULTRA SOUND	0	632,243	0	632,243		57.01
58.00	05800	MRI	0	591,100	0	591,100		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	1,611,689	0	1,611,689		59.00
60.00	06000	LABORATORY	0	13,641,984	0	13,641,984		60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0		60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	839,462	0	839,462		63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	2,889,714	0	2,889,714		65.00
66.00	06600	PHYSICAL THERAPY	0	8,835,115	0	8,835,115		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,507,896	0	1,507,896		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	10,922,332	0	10,922,332		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	10,896,599	0	10,896,599		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	391,375	26,463,314	0	26,463,314		73.00
74.00	07400	RENAL DIALYSIS	0	491,334	0	491,334		74.00
76.00	03020	OTHER ANCILLARY	0	0	0	0		76.00
76.01	03140	CARDIAC REHAB	0	2,300,629	0	2,300,629		76.01
76.02	03070	WOMEN'S CENTER	0	1,590,923	0	1,590,923		76.02
76.03	03330	ENDOSCOPY	0	0	0	0		76.03
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0		77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	894,307	0	894,307		90.00
90.01	09001	OUTPATIENT	0	1,784,730	0	1,784,730		90.01
90.02	09002	NEUROPSYCHOLOGY	0	522,194	0	522,194		90.02
91.00	09100	EMERGENCY	0	24,567,971	0	24,567,971		91.00
91.01	09101	SHORT STAY	0	0	0	0		91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	119,086	0	119,086		95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0		102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	391,375	179,049,910	0	179,049,910		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	865,914	0	865,914		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	44,357,271	0	44,357,271		192.00
192.01	19201	FOUNDATION	0	277,805	0	277,805		192.01
192.02	19202	CLINICS	0	1,466,014	0	1,466,014		192.02
192.03	19206	HOME HEALTH PARTNERSHIP	0	1,856	0	1,856		192.03
192.04	19207	WESTFIELD SCHOOLS	0	1,704,769	0	1,704,769		192.04
192.05	19203	PRACTICE MANAGEMENT	0	1,294,293	0	1,294,293		192.05
192.06	19204	MOB - NOBLESVILLE SQUARE	0	67,922	0	67,922		192.06
192.07	19208	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.07
192.08	19205	RIVERVIEW MEDICAL ARTS	0	173,982	0	173,982		192.08

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0059 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part I | Date/Time Prepared: 5/25/2023 3:52 pm

		Cost Center Description	PARAMED ED PRGM PHARMACY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			23.00	24.00	25.00	26.00		
192.09	19209	BEHAVIOR CARE	0	848,705	0	848,705		192.09
193.00	19300	NONPAID WORKERS	0	0	0	0		193.00
193.01	19301	PHYSICIAN SERVICES-LYONS	0	307	0	307		193.01
193.02	19302	UNIVERSITY HS ATHLETICS	0	66,027	0	66,027		193.02
193.03	19303	OB/GYN SPEC NEMUNAITI	0	753,453	0	753,453		193.03
193.04	19304	OB/GYN SPEC GATHERS	0	174,648	0	174,648		193.04
193.05	19305	OB SPECIALISTS DAVENPORT	0	1,092,099	0	1,092,099		193.05
193.06	19306	OUTPATIENT PHARMACY	0	5,628,589	0	5,628,589		193.06
194.00	07950	WORKMED	0	668,172	0	668,172		194.00
194.01	07951	MEALS ON WHEELS	0	504,344	0	504,344		194.01
200.00		Cross Foot Adjustments	0	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	391,375	238,996,080	0	238,996,080		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0059 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part II Date/Time Prepared: 5/25/2023 3:52 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	
			0	1.00	2A	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	78,204	78,204	78,204		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	1,613,184	1,613,184	6,140	1,619,324	5.00
7.00	00700	OPERATION OF PLANT	0	7,194,155	7,194,155	1,980	131,332	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	49,301	49,301	69	12,156	8.00
9.00	00900	HOUSEKEEPING	0	39,881	39,881	992	19,416	9.00
10.00	01000	DIETARY	0	431,039	431,039	284	9,737	10.00
11.00	01100	CAFETERIA	0	0	0	677	11,859	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	464	5,435	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	236,002	236,002	653	70,201	14.00
15.00	01500	PHARMACY	0	294,317	294,317	2,032	172,363	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	78,306	78,306	669	11,603	16.00
17.00	01700	SOCIAL SERVICE	0	55,671	55,671	600	8,434	17.00
23.00	02300	PARAMED ED PRGM PHARMACY	0	5,252	5,252	236	2,572	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	3,175,678	3,175,678	9,050	138,551	30.00
31.00	03100	INTENSIVE CARE UNIT	0	478,849	478,849	2,500	39,406	31.00
41.00	04100	SUBPROVIDER - IRF	0	506,261	506,261	1,284	24,543	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,710,194	1,710,194	4,124	80,275	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	450,251	450,251	1,865	28,484	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	243,152	243,152	428	10,883	55.00
57.00	05700	CT SCAN	0	0	0	395	4,874	57.00
57.01	03630	ULTRA SOUND	0	0	0	377	4,198	57.01
58.00	05800	MRI	0	0	0	279	3,182	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	79,966	79,966	779	9,544	59.00
60.00	06000	LABORATORY	0	491,318	491,318	2,849	85,305	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	83,694	83,694	0	4,799	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	49,877	49,877	1,390	18,667	65.00
66.00	06600	PHYSICAL THERAPY	0	159,187	159,187	4,307	56,383	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	224,854	224,854	506	7,559	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	73,828	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	31,478	31,478	0	2,995	74.00
76.00	03020	OTHER ANCILLARY	0	0	0	0	0	76.00
76.01	03140	CARDIAC REHAB	0	372,690	372,690	669	11,397	76.01
76.02	03070	WOMEN'S CENTER	0	312,309	312,309	401	7,235	76.02
76.03	03330	ENDOSCOPY	0	0	0	0	0	76.03
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	81,694	81,694	317	5,055	90.00
90.01	09001	OUTPATIENT	0	118,967	118,967	509	10,311	90.01
90.02	09002	NEUROPSYCHOLOGY	0	57,535	57,535	335	2,833	90.02
91.00	09100	EMERGENCY	0	718,409	718,409	7,609	147,649	91.00
91.01	09101	SHORT STAY	0	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	9,250	9,250	35	695	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	19,430,925	19,430,925	54,804	1,233,759	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	203,982	203,982	100	3,643	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,621,011	1,621,011	18,488	282,295	192.00
192.01	19201	FOUNDATION	0	0	0	162	1,837	192.01
192.02	19202	CLINICS	0	0	0	817	9,928	192.02
192.03	19206	HOME HEALTH PARTNERSHIP	0	0	0	0	13	192.03
192.04	19207	WESTFIELD SCHOOLS	0	0	0	1,001	11,550	192.04
192.05	19203	PRACTICE MANAGEMENT	0	0	0	345	8,765	192.05
192.06	19204	MOB - NOBLESVILLE SQUARE	0	0	0	0	460	192.06
192.07	19208	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.07

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0059 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part II | Date/Time Prepared: 5/25/2023 3:52 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	
			0	1.00	2A	4.00	5.00	
192.08	19205	RIVERVIEW MEDICAL ARTS	0	0	0	0	1,179	192.08
192.09	19209	BEHAVIOR CARE	0	0	0	423	5,750	192.09
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	PHYSICIAN SERVICES-LYONS	0	0	0	0	2	193.01
193.02	19302	UNIVERSITY HS ATHLETICS	0	0	0	40	447	193.02
193.03	19303	OB/GYN SPEC NEMUNAITI	0	0	0	437	5,105	193.03
193.04	19304	OB/GYN SPEC GATHERS	0	0	0	99	1,183	193.04
193.05	19305	OB SPECIALISTS DAVENPORT	0	0	0	645	7,399	193.05
193.06	19306	OUTPATIENT PHARMACY	0	0	0	484	38,136	193.06
194.00	07950	WORKMED	0	0	0	228	4,527	194.00
194.01	07951	MEALS ON WHEELS	0	0	0	131	3,346	194.01
200.00		Cross Foot Adjustments			0			200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	21,255,918	21,255,918	78,204	1,619,324	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0059 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part II Date/Time Prepared: 5/25/2023 3:52 pm

		Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	7,327,467					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	29,203	90,729				8.00
9.00	00900	HOUSEKEEPING	23,623	0	83,912			9.00
10.00	01000	DIETARY	255,321	0	8,879	705,260		10.00
11.00	01100	CAFETERIA	0	0	0	0	12,536	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	120	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	139,793	735	3,909	0	284	14.00
15.00	01500	PHARMACY	174,335	0	2,543	0	588	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	46,384	0	0	0	297	16.00
17.00	01700	SOCIAL SERVICE	32,976	0	507	0	175	17.00
23.00	02300	PARAMED ED PRGM PHARMACY	3,111	0	0	0	25	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,881,084	30,664	51,514	493,266	2,079	30.00
31.00	03100	INTENSIVE CARE UNIT	283,641	7,148	0	55,828	544	31.00
41.00	04100	SUBPROVIDER - IRF	299,879	7,643	0	156,166	341	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,013,016	9,494	1,827	0	1,294	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	266,701	5,728	3,170	0	550	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	144,028	791	0	0	134	55.00
57.00	05700	CT SCAN	0	0	3,170	0	113	57.00
57.01	03630	ULTRA SOUND	0	0	0	0	91	57.01
58.00	05800	MRI	0	0	3,170	0	78	58.00
59.00	05900	CARDIAC CATHETERIZATION	47,367	2,524	0	0	184	59.00
60.00	06000	LABORATORY	291,027	0	3,909	0	1,040	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	49,575	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	29,544	0	0	0	405	65.00
66.00	06600	PHYSICAL THERAPY	94,293	825	1,256	0	1,454	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	133,190	840	0	0	162	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	18,646	0	0	0	0	74.00
76.00	03020	OTHER ANCILLARY	0	0	0	0	0	76.00
76.01	03140	CARDIAC REHAB	220,759	72	0	0	237	76.01
76.02	03070	WOMEN'S CENTER	184,993	488	0	0	169	76.02
76.03	03330	ENDOSCOPY	0	0	0	0	0	76.03
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	48,391	132	0	0	125	90.00
90.01	09001	OUTPATIENT	70,469	2,658	0	0	155	90.01
90.02	09002	NEUROPSYCHOLOGY	34,080	0	0	0	99	90.02
91.00	09100	EMERGENCY	425,542	13,204	0	0	1,608	91.00
91.01	09101	SHORT STAY	0	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	5,479	0	0	0	15	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	6,246,450	82,946	83,854	705,260	12,366	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	120,827	0	58	0	47	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	960,190	7,716	0	0	0	192.00
192.01	19201	FOUNDATION	0	0	0	0	48	192.01
192.02	19202	CLINICS	0	35	0	0	0	192.02
192.03	19206	HOME HEALTH PARTNERSHIP	0	0	0	0	0	192.03
192.04	19207	WESTFIELD SCHOOLS	0	0	0	0	0	192.04
192.05	19203	PRACTICE MANAGEMENT	0	32	0	0	0	192.05
192.06	19204	MOB - NOBLESVILLE SQUARE	0	0	0	0	0	192.06
192.07	19208	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.07
192.08	19205	RIVERVIEW MEDICAL ARTS	0	0	0	0	0	192.08
192.09	19209	BEHAVIOR CARE	0	0	0	0	0	192.09
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	PHYSICIAN SERVICES-LYONS	0	0	0	0	0	193.01

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0059 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part II | Date/Time Prepared: 5/25/2023 3:52 pm

		Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
193.02	19302	UNIVERSITY HS ATHLETICS	0	0	0	0	0	193.02
193.03	19303	OB/GYN SPEC NEMUNAITI	0	0	0	0	0	193.03
193.04	19304	OB/GYN SPEC GATHERS	0	0	0	0	0	193.04
193.05	19305	OB SPECIALISTS DAVENPORT	0	0	0	0	0	193.05
193.06	19306	OUTPATIENT PHARMACY	0	0	0	0	0	193.06
194.00	07950	WORKMED	0	0	0	0	0	194.00
194.01	07951	MEALS ON WHEELS	0	0	0	0	75	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	7,327,467	90,729	83,912	705,260	12,536	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0059 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part II Date/Time Prepared: 5/25/2023 3:52 pm

		Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			13.00	14.00	15.00	16.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	6,019					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	451,577				14.00
15.00	01500	PHARMACY	0	0	646,178			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	137,259		16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	98,363	17.00
23.00	02300	PARAMED ED PRGM PHARMACY	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,738	0	0	73,977	85,024	30.00
31.00	03100	INTENSIVE CARE UNIT	716	0	0	0	6,067	31.00
41.00	04100	SUBPROVIDER - IRF	449	0	0	0	7,272	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
57.01	03630	ULTRA SOUND	0	0	0	0	0	57.01
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	451,577	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	646,178	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020	OTHER ANCILLARY	0	0	0	0	0	76.00
76.01	03140	CARDIAC REHAB	0	0	0	0	0	76.01
76.02	03070	WOMEN'S CENTER	0	0	0	0	0	76.02
76.03	03330	ENDOSCOPY	0	0	0	0	0	76.03
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OUTPATIENT	0	0	0	0	0	90.01
90.02	09002	NEUROPSYCHOLOGY	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	2,116	0	0	63,282	0	91.00
91.01	09101	SHORT STAY	0	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	6,019	451,577	646,178	137,259	98,363	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	FOUNDATION	0	0	0	0	0	192.01
192.02	19202	CLINICS	0	0	0	0	0	192.02
192.03	19206	HOME HEALTH PARTNERSHIP	0	0	0	0	0	192.03
192.04	19207	WESTFIELD SCHOOLS	0	0	0	0	0	192.04
192.05	19203	PRACTICE MANAGEMENT	0	0	0	0	0	192.05
192.06	19204	MOB - NOBLESVILLE SQUARE	0	0	0	0	0	192.06
192.07	19208	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.07
192.08	19205	RIVERVIEW MEDICAL ARTS	0	0	0	0	0	192.08
192.09	19209	BEHAVIOR CARE	0	0	0	0	0	192.09
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0059 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part II Date/Time Prepared: 5/25/2023 3:52 pm

		Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			13.00	14.00	15.00	16.00	17.00	
193.01	19301	PHYSICIAN SERVICES-LYONS	0	0	0	0	0	193.01
193.02	19302	UNIVERSITY HS ATHLETICS	0	0	0	0	0	193.02
193.03	19303	OB/GYN SPEC NEMUNAITI	0	0	0	0	0	193.03
193.04	19304	OB/GYN SPEC GATHERS	0	0	0	0	0	193.04
193.05	19305	OB SPECIALISTS DAVENPORT	0	0	0	0	0	193.05
193.06	19306	OUTPATIENT PHARMACY	0	0	0	0	0	193.06
194.00	07950	WORKMED	0	0	0	0	0	194.00
194.01	07951	MEALS ON WHEELS	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	6,019	451,577	646,178	137,259	98,363	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0059 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part II Date/Time Prepared: 5/25/2023 3:52 pm

		Cost Center Description	PARAMED ED PRGM PHARMACY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			23.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
23.00	02300	PARAMED ED PRGM PHARMACY	11,196					23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS		5,943,625	0	5,943,625		30.00
31.00	03100	INTENSIVE CARE UNIT		874,699	0	874,699		31.00
41.00	04100	SUBPROVIDER - IRF		1,003,838	0	1,003,838		41.00
43.00	04300	NURSERY		0	0	0		43.00
44.00	04400	SKILLED NURSING FACILITY		0	0	0		44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM		2,820,224	0	2,820,224		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		756,749	0	756,749		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC		399,416	0	399,416		55.00
57.00	05700	CT SCAN		8,552	0	8,552		57.00
57.01	03630	ULTRA SOUND		4,666	0	4,666		57.01
58.00	05800	MRI		6,709	0	6,709		58.00
59.00	05900	CARDIAC CATHETERIZATION		140,364	0	140,364		59.00
60.00	06000	LABORATORY		875,448	0	875,448		60.00
60.01	06001	BLOOD LABORATORY		0	0	0		60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.		138,068	0	138,068		63.00
64.00	06400	INTRAVENOUS THERAPY		0	0	0		64.00
65.00	06500	RESPIRATORY THERAPY		99,883	0	99,883		65.00
66.00	06600	PHYSICAL THERAPY		317,705	0	317,705		66.00
67.00	06700	OCCUPATIONAL THERAPY		0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY		0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY		367,111	0	367,111		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		451,577	0	451,577		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		73,828	0	73,828		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		646,178	0	646,178		73.00
74.00	07400	RENAL DIALYSIS		53,119	0	53,119		74.00
76.00	03020	OTHER ANCILLARY		0	0	0		76.00
76.01	03140	CARDIAC REHAB		605,824	0	605,824		76.01
76.02	03070	WOMEN'S CENTER		505,595	0	505,595		76.02
76.03	03330	ENDOSCOPY		0	0	0		76.03
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION		0	0	0		77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC		135,714	0	135,714		90.00
90.01	09001	OUTPATIENT		203,069	0	203,069		90.01
90.02	09002	NEUROPSYCHOLOGY		94,882	0	94,882		90.02
91.00	09100	EMERGENCY		1,379,419	0	1,379,419		91.00
91.01	09101	SHORT STAY		0	0	0		91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES		15,474	0	15,474		95.00
102.00	10200	OPIOID TREATMENT PROGRAM		0	0	0		102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	17,921,736	0	17,921,736		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN		328,657	0	328,657		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES		2,889,700	0	2,889,700		192.00
192.01	19201	FOUNDATION		2,047	0	2,047		192.01
192.02	19202	CLINICS		10,780	0	10,780		192.02
192.03	19206	HOME HEALTH PARTNERSHIP		13	0	13		192.03
192.04	19207	WESTFIELD SCHOOLS		12,551	0	12,551		192.04
192.05	19203	PRACTICE MANAGEMENT		9,142	0	9,142		192.05
192.06	19204	MOB - NOBLESVILLE SQUARE		460	0	460		192.06
192.07	19208	PHYSICIANS' PRIVATE OFFICES		0	0	0		192.07
192.08	19205	RIVERVIEW MEDICAL ARTS		1,179	0	1,179		192.08

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0059 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part II | Date/Time Prepared: 5/25/2023 3:52 pm

		Cost Center Description	PARAMED ED PRGM PHARMACY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			23.00	24.00	25.00	26.00		
192.09	19209	BEHAVIOR CARE		6,173	0	6,173		192.09
193.00	19300	NONPAID WORKERS		0	0	0		193.00
193.01	19301	PHYSICIAN SERVICES-LYONS		2	0	2		193.01
193.02	19302	UNIVERSITY HS ATHLETICS		487	0	487		193.02
193.03	19303	OB/GYN SPEC NEMUNAITI		5,542	0	5,542		193.03
193.04	19304	OB/GYN SPEC GATHERS		1,282	0	1,282		193.04
193.05	19305	OB SPECIALISTS DAVENPORT		8,044	0	8,044		193.05
193.06	19306	OUTPATIENT PHARMACY		38,620	0	38,620		193.06
194.00	07950	WORKMED		4,755	0	4,755		194.00
194.01	07951	MEALS ON WHEELS		3,552	0	3,552		194.01
200.00		Cross Foot Adjustments	11,196	11,196	0	11,196		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	11,196	21,255,918	0	21,255,918		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0059 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B-1 | Date/Time Prepared: 5/25/2023 3:52 pm

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
			1.00	4.00	5A	5.00	7.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	627,314					1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,308	93,081,098				4.00
5.00	00500	ADMINISTRATIVE & GENERAL	47,609	7,309,672	-30,809,396	208,186,684		5.00
7.00	00700	OPERATION OF PLANT	212,317	2,357,346	0	16,885,076	365,080	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,455	82,569	0	1,562,920	1,455	8.00
9.00	00900	HOUSEKEEPING	1,177	1,181,088	0	2,496,301	1,177	9.00
10.00	01000	DIETARY	12,721	338,088	0	1,251,806	12,721	10.00
11.00	01100	CAFETERIA	0	805,780	0	1,524,622	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	552,063	0	698,748	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	6,965	777,394	0	9,025,587	6,965	14.00
15.00	01500	PHARMACY	8,686	2,418,630	0	22,160,363	8,686	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,311	796,689	0	1,491,817	2,311	16.00
17.00	01700	SOCIAL SERVICE	1,643	714,588	0	1,084,373	1,643	17.00
23.00	02300	PARAMED ED PRGM PHARMACY	155	281,411	0	330,716	155	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	93,722	10,774,051	0	17,813,240	93,722	30.00
31.00	03100	INTENSIVE CARE UNIT	14,132	2,975,944	0	5,066,307	14,132	31.00
41.00	04100	SUBPROVIDER - IRF	14,941	1,528,814	0	3,155,427	14,941	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	50,472	4,909,865	0	10,320,715	50,472	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	13,288	2,219,802	0	3,662,156	13,288	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	7,176	508,954	0	1,399,239	7,176	55.00
57.00	05700	CT SCAN	0	469,787	0	626,590	0	57.00
57.01	03630	ULTRA SOUND	0	448,660	0	539,722	0	57.01
58.00	05800	MRI	0	332,689	0	409,078	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,360	927,536	0	1,226,990	2,360	59.00
60.00	06000	LABORATORY	14,500	3,392,101	0	10,967,478	14,500	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	2,470	0	0	617,008	2,470	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,472	1,654,638	0	2,399,923	1,472	65.00
66.00	06600	PHYSICAL THERAPY	4,698	5,127,607	0	7,249,072	4,698	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	6,636	602,834	0	971,831	6,636	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	9,491,902	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	929	0	0	385,029	929	74.00
76.00	03020	OTHER ANCILLARY	0	0	0	0	0	76.00
76.01	03140	CARDIAC REHAB	10,999	796,262	0	1,465,268	10,999	76.01
76.02	03070	WOMEN'S CENTER	9,217	477,213	0	930,165	9,217	76.02
76.03	03330	ENDOSCOPY	0	0	0	0	0	76.03
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,411	377,203	0	649,902	2,411	90.00
90.01	09001	OUTPATIENT	3,511	606,534	0	1,325,693	3,511	90.01
90.02	09002	NEUROPSYCHOLOGY	1,698	398,572	0	364,292	1,698	90.02
91.00	09100	EMERGENCY	21,202	9,058,665	0	18,982,904	21,202	91.00
91.01	09101	SHORT STAY	0	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	273	41,802	0	89,323	273	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	573,454	65,244,851	-30,809,396	158,621,583	311,220	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	6,020	118,547	0	468,414	6,020	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	47,840	21,987,162	0	36,287,795	47,840	192.00
192.01	19201	FOUNDATION	0	192,673	0	236,180	0	192.01
192.02	19202	CLINICS	0	972,896	0	1,276,403	0	192.02
192.03	19206	HOME HEALTH PARTNERSHIP	0	0	0	1,617	0	192.03
192.04	19207	WESTFIELD SCHOOLS	0	1,192,253	0	1,485,005	0	192.04
192.05	19203	PRACTICE MANAGEMENT	0	411,136	0	1,126,867	0	192.05
192.06	19204	MOB - NOBLESVILLE SQUARE	0	0	0	59,166	0	192.06

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0059 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B-1 | Date/Time Prepared: 5/25/2023 3:52 pm

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
			1.00	4.00	5A	5.00	7.00	
192.07	19208	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.07
192.08	19205	RIVERVIEW MEDICAL ARTS	0	0	0	151,554	0	192.08
192.09	19209	BEHAVIOR CARE	0	503,969	0	739,297	0	192.09
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	PHYSICIAN SERVICES-LYONS	0	0	0	267	0	193.01
193.02	19302	UNIVERSITY HS ATHLETICS	0	47,634	0	57,515	0	193.02
193.03	19303	OB/GYN SPEC NEMUNAITI	0	520,739	0	656,324	0	193.03
193.04	19304	OB/GYN SPEC GATHERS	0	117,491	0	152,134	0	193.04
193.05	19305	OB SPECIALISTS DAVENPORT	0	768,142	0	951,315	0	193.05
193.06	19306	OUTPATIENT PHARMACY	0	576,634	0	4,902,999	0	193.06
194.00	07950	WORKMED	0	271,423	0	582,037	0	194.00
194.01	07951	MEALS ON WHEELS	0	155,548	0	430,212	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	21,255,918	9,692,109		30,809,396	19,383,882	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	33.884017	0.104125		0.147989	53.094889	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		78,204		1,619,324	7,327,467	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.000840		0.007778	20.070853	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: 15-0059 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B-1 | Date/Time Prepared: 5/25/2023 3:52 pm

		Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDR)	HOUSEKEEPING (HOURS OF SERVIC)	DIETARY (MEALS SERVED)	CAFETERIA (MAN HOURS)	NURSING ADMINISTRATION (DIRECT NRSING HR)	
			8.00	9.00	10.00	11.00	13.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE	67,867					8.00
9.00	00900	HOUSEKEEPING	0	25,998				9.00
10.00	01000	DIETARY	0	2,751	69,164			10.00
11.00	01100	CAFETERIA	0	0	0	1,225,113		11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	11,694	447,024	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	550	1,211	0	27,779	0	14.00
15.00	01500	PHARMACY	0	788	0	57,502	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	29,042	0	16.00
17.00	01700	SOCIAL SERVICE	0	157	0	17,055	0	17.00
23.00	02300	PARAMED ED PRGM PHARMACY	0	0	0	2,441	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	22,936	15,961	48,374	203,345	203,345	30.00
31.00	03100	INTENSIVE CARE UNIT	5,347	0	5,475	53,148	53,148	31.00
41.00	04100	SUBPROVIDER - IRF	5,717	0	15,315	33,358	33,358	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,102	566	0	126,448	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,285	982	0	53,724	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	592	0	0	13,051	0	55.00
57.00	05700	CT SCAN	0	982	0	11,087	0	57.00
57.01	03630	ULTRA SOUND	0	0	0	8,853	0	57.01
58.00	05800	MRI	0	982	0	7,614	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,888	0	0	18,025	0	59.00
60.00	06000	LABORATORY	0	1,211	0	101,611	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	39,529	0	65.00
66.00	06600	PHYSICAL THERAPY	617	389	0	142,087	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	628	0	0	15,812	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020	OTHER ANCILLARY	0	0	0	0	0	76.00
76.01	03140	CARDIAC REHAB	54	0	0	23,125	0	76.01
76.02	03070	WOMEN'S CENTER	365	0	0	16,563	0	76.02
76.03	03330	ENDOSCOPY	0	0	0	0	0	76.03
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	99	0	0	12,239	0	90.00
90.01	09001	OUTPATIENT	1,988	0	0	15,128	0	90.01
90.02	09002	NEUROPSYCHOLOGY	0	0	0	9,685	0	90.02
91.00	09100	EMERGENCY	9,877	0	0	157,173	157,173	91.00
91.01	09101	SHORT STAY	0	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	1,434	0	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	62,045	25,980	69,164	1,208,552	447,024	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	18	0	4,565	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	5,772	0	0	0	0	192.00
192.01	19201	FOUNDATION	0	0	0	4,671	0	192.01
192.02	19202	CLINICS	26	0	0	0	0	192.02
192.03	19206	HOME HEALTH PARTNERSHIP	0	0	0	0	0	192.03
192.04	19207	WESTFIELD SCHOOLS	0	0	0	0	0	192.04
192.05	19203	PRACTICE MANAGEMENT	24	0	0	0	0	192.05
192.06	19204	MOB - NOBLESVILLE SQUARE	0	0	0	0	0	192.06
192.07	19208	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.07
192.08	19205	RIVERVIEW MEDICAL ARTS	0	0	0	0	0	192.08

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0059 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B-1 | Date/Time Prepared: 5/25/2023 3:52 pm

		Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDR)	HOUSEKEEPING (HOURS OF SERVIC)	DIETARY (MEALS SERVED)	CAFETERIA (MAN HOURS)	NURSING ADMINISTRATION (DIRECT NRSING HR)	
			8.00	9.00	10.00	11.00	13.00	
192.09	19209	BEHAVIOR CARE	0	0	0	0	0	192.09
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	PHYSICIAN SERVICES-LYONS	0	0	0	0	0	193.01
193.02	19302	UNIVERSITY HS ATHLETICS	0	0	0	0	0	193.02
193.03	19303	OB/GYN SPEC NEMUNAITI	0	0	0	0	0	193.03
193.04	19304	OB/GYN SPEC GATHERS	0	0	0	0	0	193.04
193.05	19305	OB SPECIALISTS DAVENPORT	0	0	0	0	0	193.05
193.06	19306	OUTPATIENT PHARMACY	0	0	0	0	0	193.06
194.00	07950	WORKMED	0	0	0	0	0	194.00
194.01	07951	MEALS ON WHEELS	0	0	0	7,325	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,871,468	2,928,219	2,422,332	1,750,249	818,862	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	27.575523	112.632472	35.023018	1.428643	1.831808	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	90,729	83,912	705,260	12,536	6,019	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1.336865	3.227633	10.196923	0.010233	0.013465	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: 15-0059 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B-1 | Date/Time Prepared: 5/25/2023 3:52 pm

		Cost Center Description	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	PARAMED ED PRGM PHARMACY (ASSIGNED TIME)	
			14.00	15.00	16.00	17.00	23.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	100					14.00
15.00	01500	PHARMACY	0	100				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	308			16.00
17.00	01700	SOCIAL SERVICE	0	0	0	4,653		17.00
23.00	02300	PARAMED ED PRGM PHARMACY	0	0	0	0	100	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	166	4,022	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	287	0	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	344	0	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
57.01	03630	ULTRA SOUND	0	0	0	0	0	57.01
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	100	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	100	0	0	100	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020	OTHER ANCILLARY	0	0	0	0	0	76.00
76.01	03140	CARDIAC REHAB	0	0	0	0	0	76.01
76.02	03070	WOMEN'S CENTER	0	0	0	0	0	76.02
76.03	03330	ENDOSCOPY	0	0	0	0	0	76.03
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OUTPATIENT	0	0	0	0	0	90.01
90.02	09002	NEUROPSYCHOLOGY	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	0	0	142	0	0	91.00
91.01	09101	SHORT STAY	0	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	100	100	308	4,653	100	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	FOUNDATION	0	0	0	0	0	192.01
192.02	19202	CLINICS	0	0	0	0	0	192.02
192.03	19206	HOME HEALTH PARTNERSHIP	0	0	0	0	0	192.03
192.04	19207	WESTFIELD SCHOOLS	0	0	0	0	0	192.04
192.05	19203	PRACTICE MANAGEMENT	0	0	0	0	0	192.05
192.06	19204	MOB - NOBLESVILLE SQUARE	0	0	0	0	0	192.06
192.07	19208	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.07
192.08	19205	RIVERVIEW MEDICAL ARTS	0	0	0	0	0	192.08

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0059 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B-1 | Date/Time Prepared: 5/25/2023 3:52 pm

		Cost Center Description	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	PARAMED ED PRGM PHARMACY (ASSIGNED TIME)	
			14.00	15.00	16.00	17.00	23.00	
192.09	19209	BEHAVIOR CARE	0	0	0	0	0	192.09
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	PHYSICIAN SERVICES-LYONS	0	0	0	0	0	193.01
193.02	19302	UNIVERSITY HS ATHLETICS	0	0	0	0	0	193.02
193.03	19303	OB/GYN SPEC NEMUNAITI	0	0	0	0	0	193.03
193.04	19304	OB/GYN SPEC GATHERS	0	0	0	0	0	193.04
193.05	19305	OB SPECIALISTS DAVENPORT	0	0	0	0	0	193.05
193.06	19306	OUTPATIENT PHARMACY	0	0	0	0	0	193.06
194.00	07950	WORKMED	0	0	0	0	0	194.00
194.01	07951	MEALS ON WHEELS	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	10,922,332	26,071,939	1,876,783	1,374,132	391,375	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	109,223.32000	260,719.39000	6,093.451299	295.321728	3,913.750000	203.00
			0	0				
204.00		Cost to be allocated (per Wkst. B, Part II)	451,577	646,178	137,259	98,363	11,196	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	4,515.770000	6,461.780000	445.646104	21.139695	111.960000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)					0	206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)					0.000000	207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0059 | Period: From 01/01/2022 To 12/31/2022 | Worksheet C Part I Date/Time Prepared: 5/25/2023 3:52 pm

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		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	32,412,257		32,412,257	0	32,412,257	30.00
31.00	03100	INTENSIVE CARE UNIT	7,163,643		7,163,643	0	7,163,643	31.00
41.00	04100	SUBPROVIDER - IRF	5,320,066		5,320,066	0	5,320,066	41.00
43.00	04300	NURSERY	0		0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0		0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	14,968,112		14,968,112	0	14,968,112	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,215,158		5,215,158	0	5,215,158	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	2,022,290		2,022,290	0	2,022,290	55.00
57.00	05700	CT SCAN	845,762		845,762	0	845,762	57.00
57.01	03630	ULTRA SOUND	632,243		632,243	0	632,243	57.01
58.00	05800	MRI	591,100		591,100	0	591,100	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,611,689		1,611,689	0	1,611,689	59.00
60.00	06000	LABORATORY	13,641,984		13,641,984	0	13,641,984	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	839,462		839,462	0	839,462	63.00
64.00	06400	INTRAVENOUS THERAPY	0		0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	2,889,714	0	2,889,714	0	2,889,714	65.00
66.00	06600	PHYSICAL THERAPY	8,835,115	0	8,835,115	0	8,835,115	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	1,507,896		1,507,896	0	1,507,896	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	10,922,332		10,922,332	0	10,922,332	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	10,896,599		10,896,599	0	10,896,599	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	26,463,314		26,463,314	0	26,463,314	73.00
74.00	07400	RENAL DIALYSIS	491,334		491,334	0	491,334	74.00
76.00	03020	OTHER ANCILLARY	0		0	0	0	76.00
76.01	03140	CARDIAC REHAB	2,300,629		2,300,629	0	2,300,629	76.01
76.02	03070	WOMEN'S CENTER	1,590,923		1,590,923	0	1,590,923	76.02
76.03	03330	ENDOSCOPY	0		0	0	0	76.03
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0		0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	894,307		894,307	0	894,307	90.00
90.01	09001	OUTPATIENT	1,784,730		1,784,730	0	1,784,730	90.01
90.02	09002	NEUROPSYCHOLOGY	522,194		522,194	0	522,194	90.02
91.00	09100	EMERGENCY	24,567,971		24,567,971	0	24,567,971	91.00
91.01	09101	SHORT STAY	0		0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	5,671,575		5,671,575		5,671,575	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	119,086		119,086	0	119,086	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0		0		0	102.00
200.00		Subtotal (see instructions)	184,721,485	0	184,721,485	0	184,721,485	200.00
201.00		Less Observation Beds	5,671,575		5,671,575		5,671,575	201.00
202.00		Total (see instructions)	179,049,910	0	179,049,910	0	179,049,910	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0059 | Period: From 01/01/2022 To 12/31/2022 | Worksheet C Part I | Date/Time Prepared: 5/25/2023 3:52 pm

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		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	40,786,691		40,786,691			30.00
31.00	03100	INTENSIVE CARE UNIT	10,991,986		10,991,986			31.00
41.00	04100	SUBPROVIDER - IRF	6,394,836		6,394,836			41.00
43.00	04300	NURSERY	0		0			43.00
44.00	04400	SKILLED NURSING FACILITY	0		0			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	15,532,730	93,006,663	108,539,393	0.137905	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,995,011	13,348,805	15,343,816	0.339887	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	188,175	9,896,428	10,084,603	0.200532	0.000000	55.00
57.00	05700	CT SCAN	4,863,154	20,578,173	25,441,327	0.033244	0.000000	57.00
57.01	03630	ULTRA SOUND	1,300,588	9,602,240	10,902,828	0.057989	0.000000	57.01
58.00	05800	MRI	712,797	6,808,791	7,521,588	0.078587	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	8,513,583	16,423,552	24,937,135	0.064630	0.000000	59.00
60.00	06000	LABORATORY	18,588,952	51,636,133	70,225,085	0.194261	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	1,247,413	601,884	1,849,297	0.453936	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0.000000	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	6,014,699	2,283,465	8,298,164	0.348235	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	7,659,601	24,384,725	32,044,326	0.275715	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	2,949,401	8,339,830	11,289,231	0.133569	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	16,939,052	33,238,781	50,177,833	0.217672	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,656,559	23,342,251	28,998,810	0.375760	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	13,118,416	50,541,873	63,660,289	0.415696	0.000000	73.00
74.00	07400	RENAL DIALYSIS	918,202	5,637	923,839	0.531839	0.000000	74.00
76.00	03020	OTHER ANCILLARY	0	0	0	0.000000	0.000000	76.00
76.01	03140	CARDIAC REHAB	578,003	15,258,698	15,836,701	0.145272	0.000000	76.01
76.02	03070	WOMEN'S CENTER	96,443	8,601,340	8,697,783	0.182911	0.000000	76.02
76.03	03330	ENDOSCOPY	0	0	0	0.000000	0.000000	76.03
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0.000000	0.000000	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	13,848	6,048,322	6,062,170	0.147523	0.000000	90.00
90.01	09001	OUTPATIENT	283,146	7,618,276	7,901,422	0.225875	0.000000	90.01
90.02	09002	NEUROPSYCHOLOGY	0	2,715,354	2,715,354	0.192312	0.000000	90.02
91.00	09100	EMERGENCY	6,247,764	66,442,689	72,690,453	0.337981	0.000000	91.00
91.01	09101	SHORT STAY	0	0	0	0.000000	0.000000	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,120,839	6,643,878	7,764,717	0.730429	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0			102.00
200.00		Subtotal (see instructions)	172,711,889	477,367,788	650,079,677			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	172,711,889	477,367,788	650,079,677			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0059 | Period: From 01/01/2022 To 12/31/2022 | Worksheet C Part I Date/Time Prepared: 5/25/2023 3:52 pm

Title XVIII | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
41.00	04100	SUBPROVIDER - IRF		41.00
43.00	04300	NURSERY		43.00
44.00	04400	SKILLED NURSING FACILITY		44.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.137905	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.339887	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.200532	55.00
57.00	05700	CT SCAN	0.033244	57.00
57.01	03630	ULTRA SOUND	0.057989	57.01
58.00	05800	MRI	0.078587	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.064630	59.00
60.00	06000	LABORATORY	0.194261	60.00
60.01	06001	BLOOD LABORATORY	0.000000	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.453936	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0.348235	65.00
66.00	06600	PHYSICAL THERAPY	0.275715	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0.133569	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.217672	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.375760	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.415696	73.00
74.00	07400	RENAL DIALYSIS	0.531839	74.00
76.00	03020	OTHER ANCILLARY	0.000000	76.00
76.01	03140	CARDIAC REHAB	0.145272	76.01
76.02	03070	WOMEN'S CENTER	0.182911	76.02
76.03	03330	ENDOSCOPY	0.000000	76.03
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0.000000	77.00
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	0.147523	90.00
90.01	09001	OUTPATIENT	0.225875	90.01
90.02	09002	NEUROPSYCHOLOGY	0.192312	90.02
91.00	09100	EMERGENCY	0.337981	91.00
91.01	09101	SHORT STAY	0.000000	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.730429	92.00
		OTHER REIMBURSABLE COST CENTERS		
95.00	09500	AMBULANCE SERVICES	0.000000	95.00
102.00	10200	OPIOID TREATMENT PROGRAM		102.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0059 | Period: From 01/01/2022 To 12/31/2022 | Worksheet C Part I Date/Time Prepared: 5/25/2023 3:52 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	32,412,257		32,412,257	0	32,412,257	30.00
31.00	03100	INTENSIVE CARE UNIT	7,163,643		7,163,643	0	7,163,643	31.00
41.00	04100	SUBPROVIDER - IRF	5,320,066		5,320,066	0	5,320,066	41.00
43.00	04300	NURSERY	0		0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0		0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	14,968,112		14,968,112	0	14,968,112	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,215,158		5,215,158	0	5,215,158	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	2,022,290		2,022,290	0	2,022,290	55.00
57.00	05700	CT SCAN	845,762		845,762	0	845,762	57.00
57.01	03630	ULTRA SOUND	632,243		632,243	0	632,243	57.01
58.00	05800	MRI	591,100		591,100	0	591,100	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,611,689		1,611,689	0	1,611,689	59.00
60.00	06000	LABORATORY	13,641,984		13,641,984	0	13,641,984	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	839,462		839,462	0	839,462	63.00
64.00	06400	INTRAVENOUS THERAPY	0		0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	2,889,714	0	2,889,714	0	2,889,714	65.00
66.00	06600	PHYSICAL THERAPY	8,835,115	0	8,835,115	0	8,835,115	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	1,507,896		1,507,896	0	1,507,896	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	10,922,332		10,922,332	0	10,922,332	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	10,896,599		10,896,599	0	10,896,599	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	26,463,314		26,463,314	0	26,463,314	73.00
74.00	07400	RENAL DIALYSIS	491,334		491,334	0	491,334	74.00
76.00	03020	OTHER ANCILLARY	0		0	0	0	76.00
76.01	03140	CARDIAC REHAB	2,300,629		2,300,629	0	2,300,629	76.01
76.02	03070	WOMEN'S CENTER	1,590,923		1,590,923	0	1,590,923	76.02
76.03	03330	ENDOSCOPY	0		0	0	0	76.03
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0		0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	894,307		894,307	0	894,307	90.00
90.01	09001	OUTPATIENT	1,784,730		1,784,730	0	1,784,730	90.01
90.02	09002	NEUROPSYCHOLOGY	522,194		522,194	0	522,194	90.02
91.00	09100	EMERGENCY	24,567,971		24,567,971	0	24,567,971	91.00
91.01	09101	SHORT STAY	0		0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	5,671,575		5,671,575		5,671,575	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	119,086		119,086	0	119,086	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0		0		0	102.00
200.00		Subtotal (see instructions)	184,721,485	0	184,721,485	0	184,721,485	200.00
201.00		Less Observation Beds	5,671,575		5,671,575		5,671,575	201.00
202.00		Total (see instructions)	179,049,910	0	179,049,910	0	179,049,910	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0059 | Period: From 01/01/2022 To 12/31/2022 | Worksheet C Part I Date/Time Prepared: 5/25/2023 3:52 pm

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	40,786,691		40,786,691			30.00
31.00	03100	INTENSIVE CARE UNIT	10,991,986		10,991,986			31.00
41.00	04100	SUBPROVIDER - IRF	6,394,836		6,394,836			41.00
43.00	04300	NURSERY	0		0			43.00
44.00	04400	SKILLED NURSING FACILITY	0		0			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	15,532,730	93,006,663	108,539,393	0.137905	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,995,011	13,348,805	15,343,816	0.339887	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	188,175	9,896,428	10,084,603	0.200532	0.000000	55.00
57.00	05700	CT SCAN	4,863,154	20,578,173	25,441,327	0.033244	0.000000	57.00
57.01	03630	ULTRA SOUND	1,300,588	9,602,240	10,902,828	0.057989	0.000000	57.01
58.00	05800	MRI	712,797	6,808,791	7,521,588	0.078587	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	8,513,583	16,423,552	24,937,135	0.064630	0.000000	59.00
60.00	06000	LABORATORY	18,588,952	51,636,133	70,225,085	0.194261	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	1,247,413	601,884	1,849,297	0.453936	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0.000000	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	6,014,699	2,283,465	8,298,164	0.348235	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	7,659,601	24,384,725	32,044,326	0.275715	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	2,949,401	8,339,830	11,289,231	0.133569	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	16,939,052	33,238,781	50,177,833	0.217672	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,656,559	23,342,251	28,998,810	0.375760	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	13,118,416	50,541,873	63,660,289	0.415696	0.000000	73.00
74.00	07400	RENAL DIALYSIS	918,202	5,637	923,839	0.531839	0.000000	74.00
76.00	03020	OTHER ANCILLARY	0	0	0	0.000000	0.000000	76.00
76.01	03140	CARDIAC REHAB	578,003	15,258,698	15,836,701	0.145272	0.000000	76.01
76.02	03070	WOMEN'S CENTER	96,443	8,601,340	8,697,783	0.182911	0.000000	76.02
76.03	03330	ENDOSCOPY	0	0	0	0.000000	0.000000	76.03
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0.000000	0.000000	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	13,848	6,048,322	6,062,170	0.147523	0.000000	90.00
90.01	09001	OUTPATIENT	283,146	7,618,276	7,901,422	0.225875	0.000000	90.01
90.02	09002	NEUROPSYCHOLOGY	0	2,715,354	2,715,354	0.192312	0.000000	90.02
91.00	09100	EMERGENCY	6,247,764	66,442,689	72,690,453	0.337981	0.000000	91.00
91.01	09101	SHORT STAY	0	0	0	0.000000	0.000000	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,120,839	6,643,878	7,764,717	0.730429	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0			102.00
200.00		Subtotal (see instructions)	172,711,889	477,367,788	650,079,677			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	172,711,889	477,367,788	650,079,677			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0059 | Period: From 01/01/2022 To 12/31/2022 | Worksheet C Part I Date/Time Prepared: 5/25/2023 3:52 pm

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
41.00	04100	SUBPROVIDER - IRF			41.00
43.00	04300	NURSERY			43.00
44.00	04400	SKILLED NURSING FACILITY			44.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000		55.00
57.00	05700	CT SCAN	0.000000		57.00
57.01	03630	ULTRA SOUND	0.000000		57.01
58.00	05800	MRI	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000	LABORATORY	0.000000		60.00
60.01	06001	BLOOD LABORATORY	0.000000		60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000		63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000		64.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
74.00	07400	RENAL DIALYSIS	0.000000		74.00
76.00	03020	OTHER ANCILLARY	0.000000		76.00
76.01	03140	CARDIAC REHAB	0.000000		76.01
76.02	03070	WOMEN'S CENTER	0.000000		76.02
76.03	03330	ENDOSCOPY	0.000000		76.03
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0.000000		77.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	OUTPATIENT	0.000000		90.01
90.02	09002	NEUROPSYCHOLOGY	0.000000		90.02
91.00	09100	EMERGENCY	0.000000		91.00
91.01	09101	SHORT STAY	0.000000		91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
102.00	10200	OPIOID TREATMENT PROGRAM			102.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-0059 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part I Date/Time Prepared: 5/25/2023 3:52 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	5,943,625	0	5,943,625	15,413	385.62	30.00
31.00	INTENSIVE CARE UNIT	874,699		874,699	3,181	274.98	31.00
41.00	SUBPROVIDER - IRF	1,003,838	0	1,003,838	3,987	251.78	41.00
43.00	NURSERY	0		0	1,518	0.00	43.00
44.00	SKILLED NURSING FACILITY	0		0	0	0.00	44.00
200.00	Total (lines 30 through 199)	7,822,162		7,822,162	24,099		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	3,873	1,493,506	30.00
31.00	INTENSIVE CARE UNIT	878	241,432	31.00
41.00	SUBPROVIDER - IRF	2,096	527,731	41.00
43.00	NURSERY	0	0	43.00
44.00	SKILLED NURSING FACILITY	0	0	44.00
200.00	Total (lines 30 through 199)	6,847	2,262,669	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-0059 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part II Date/Time Prepared: 5/25/2023 3:52 pm

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		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,820,224	108,539,393	0.025983	3,965,413	103,033	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	756,749	15,343,816	0.049319	792,312	39,076	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	399,416	10,084,603	0.039607	107,625	4,263	55.00
57.00	05700	CT SCAN	8,552	25,441,327	0.000336	1,512,935	508	57.00
57.01	03630	ULTRA SOUND	4,666	10,902,828	0.000428	346,738	148	57.01
58.00	05800	MRI	6,709	7,521,588	0.000892	188,561	168	58.00
59.00	05900	CARDIAC CATHETERIZATION	140,364	24,937,135	0.005629	2,232,233	12,565	59.00
60.00	06000	LABORATORY	875,448	70,225,085	0.012466	5,159,198	64,315	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	138,068	1,849,297	0.074660	134,857	10,068	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	99,883	8,298,164	0.012037	1,981,694	23,854	65.00
66.00	06600	PHYSICAL THERAPY	317,705	32,044,326	0.009915	1,068,032	10,590	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	367,111	11,289,231	0.032519	886,148	28,817	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	451,577	50,177,833	0.009000	4,111,650	37,005	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	73,828	28,998,810	0.002546	1,468,240	3,738	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	646,178	63,660,289	0.010150	3,425,835	34,772	73.00
74.00	07400	RENAL DIALYSIS	53,119	923,839	0.057498	222,841	12,813	74.00
76.00	03020	OTHER ANCILLARY	0	0	0.000000	0	0	76.00
76.01	03140	CARDIAC REHAB	605,824	15,836,701	0.038254	155,729	5,957	76.01
76.02	03070	WOMEN'S CENTER	505,595	8,697,783	0.058129	77,586	4,510	76.02
76.03	03330	ENDOSCOPY	0	0	0.000000	0	0	76.03
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0.000000	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	135,714	6,062,170	0.022387	8,606	193	90.00
90.01	09001	OUTPATIENT	203,069	7,901,422	0.025700	70,038	1,800	90.01
90.02	09002	NEUROPSYCHOLOGY	94,882	2,715,354	0.034943	0	0	90.02
91.00	09100	EMERGENCY	1,379,419	72,690,453	0.018977	2,028,893	38,502	91.00
91.01	09101	SHORT STAY	0	0	0.000000	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,040,031	7,764,717	0.133943	292,512	39,180	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	11,124,131	591,906,164		30,237,676	475,875	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0059 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part III Date/Time Prepared: 5/25/2023 3:52 pm

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		Cost Center Description	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0		44.00
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	15,413	0.00	3,873	30.00
31.00	03100	INTENSIVE CARE UNIT		0	3,181	0.00	878	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	3,987	0.00	2,096	41.00
43.00	04300	NURSERY		0	1,518	0.00	0	43.00
44.00	04400	SKILLED NURSING FACILITY		0	0	0.00	0	44.00
200.00		Total (lines 30 through 199)		0	24,099		6,847	200.00

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

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0059 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part IV Date/Time Prepared: 5/25/2023 3:52 pm

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
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
57.01	03630	ULTRA SOUND	0	0	0	0	0	57.01
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	391,375	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020	OTHER ANCILLARY	0	0	0	0	0	76.00
76.01	03140	CARDIAC REHAB	0	0	0	0	0	76.01
76.02	03070	WOMEN'S CENTER	0	0	0	0	0	76.02
76.03	03330	ENDOSCOPY	0	0	0	0	0	76.03
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OUTPATIENT	0	0	0	0	0	90.01
90.02	09002	NEUROPSYCHOLOGY	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
91.01	09101	SHORT STAY	0	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	0	391,375	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0059 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part IV | Date/Time Prepared: 5/25/2023 3:52 pm

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	108,539,393	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	15,343,816	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	10,084,603	0.000000	55.00
57.00	05700	CT SCAN	0	0	0	25,441,327	0.000000	57.00
57.01	03630	ULTRA SOUND	0	0	0	10,902,828	0.000000	57.01
58.00	05800	MRI	0	0	0	7,521,588	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	24,937,135	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	70,225,085	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0.000000	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	1,849,297	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	8,298,164	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	32,044,326	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	11,289,231	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	50,177,833	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	28,998,810	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	391,375	391,375	63,660,289	0.006148	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	923,839	0.000000	74.00
76.00	03020	OTHER ANCILLARY	0	0	0	0	0.000000	76.00
76.01	03140	CARDIAC REHAB	0	0	0	15,836,701	0.000000	76.01
76.02	03070	WOMEN'S CENTER	0	0	0	8,697,783	0.000000	76.02
76.03	03330	ENDOSCOPY	0	0	0	0	0.000000	76.03
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0.000000	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	6,062,170	0.000000	90.00
90.01	09001	OUTPATIENT	0	0	0	7,901,422	0.000000	90.01
90.02	09002	NEUROPSYCHOLOGY	0	0	0	2,715,354	0.000000	90.02
91.00	09100	EMERGENCY	0	0	0	72,690,453	0.000000	91.00
91.01	09101	SHORT STAY	0	0	0	0	0.000000	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	7,764,717	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	391,375	391,375	591,906,164		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0059 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part IV Date/Time Prepared: 5/25/2023 3:52 pm

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		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	3,965,413	0	16,478,086	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	792,312	0	3,154,258	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	107,625	0	3,221,037	0	55.00
57.00	05700	CT SCAN	0.000000	1,512,935	0	5,184,636	0	57.00
57.01	03630	ULTRA SOUND	0.000000	346,738	0	1,422,298	0	57.01
58.00	05800	MRI	0.000000	188,561	0	1,509,290	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	2,232,233	0	5,382,084	0	59.00
60.00	06000	LABORATORY	0.000000	5,159,198	0	4,383,992	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	134,857	0	53,950	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	1,981,694	0	651,309	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	1,068,032	0	202,111	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	886,148	0	1,609,801	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	4,111,650	0	6,707,019	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	1,468,240	0	6,356,277	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.006148	3,425,835	21,062	19,217,559	118,150	73.00
74.00	07400	RENAL DIALYSIS	0.000000	222,841	0	0	0	74.00
76.00	03020	OTHER ANCILLARY	0.000000	0	0	0	0	76.00
76.01	03140	CARDIAC REHAB	0.000000	155,729	0	5,038,793	0	76.01
76.02	03070	WOMEN'S CENTER	0.000000	77,586	0	976,763	0	76.02
76.03	03330	ENDOSCOPY	0.000000	0	0	0	0	76.03
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0.000000	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	8,606	0	2,893,807	0	90.00
90.01	09001	OUTPATIENT	0.000000	70,038	0	2,606,882	0	90.01
90.02	09002	NEUROPSYCHOLOGY	0.000000	0	0	979,344	0	90.02
91.00	09100	EMERGENCY	0.000000	2,028,893	0	6,477,986	0	91.00
91.01	09101	SHORT STAY	0.000000	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	292,512	0	29,205	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		30,237,676	21,062	94,536,487	118,150	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0059 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part V Date/Time Prepared: 5/25/2023 3:52 pm

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		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.137905	16,478,086	0	0	2,272,410	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.339887	3,154,258	0	0	1,072,091	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.200532	3,221,037	0	0	645,921	55.00
57.00	05700	CT SCAN	0.033244	5,184,636	0	0	172,358	57.00
57.01	03630	ULTRA SOUND	0.057989	1,422,298	0	0	82,478	57.01
58.00	05800	MRI	0.078587	1,509,290	0	0	118,611	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.064630	5,382,084	0	0	347,844	59.00
60.00	06000	LABORATORY	0.194261	4,383,992	384	0	851,639	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.453936	53,950	0	0	24,490	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.348235	651,309	0	0	226,809	65.00
66.00	06600	PHYSICAL THERAPY	0.275715	202,111	0	0	55,725	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.133569	1,609,801	0	0	215,020	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.217672	6,707,019	74	0	1,459,930	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.375760	6,356,277	0	0	2,388,435	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.415696	19,217,559	0	21,741	7,988,662	73.00
74.00	07400	RENAL DIALYSIS	0.531839	0	0	0	0	74.00
76.00	03020	OTHER ANCILLARY	0.000000	0	0	0	0	76.00
76.01	03140	CARDIAC REHAB	0.145272	5,038,793	0	0	731,996	76.01
76.02	03070	WOMEN'S CENTER	0.182911	976,763	0	0	178,661	76.02
76.03	03330	ENDOSCOPY	0.000000	0	0	0	0	76.03
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0.000000	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.147523	2,893,807	0	0	426,903	90.00
90.01	09001	OUTPATIENT	0.225875	2,606,882	0	0	588,829	90.01
90.02	09002	NEUROPSYCHOLOGY	0.192312	979,344	0	0	188,340	90.02
91.00	09100	EMERGENCY	0.337981	6,477,986	0	0	2,189,436	91.00
91.01	09101	SHORT STAY	0.000000	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.730429	29,205	0	0	21,332	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000		0			95.00
200.00		Subtotal (see instructions)		94,536,487	458	21,741	22,247,920	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		94,536,487	458	21,741	22,247,920	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0059 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part V Date/Time Prepared: 5/25/2023 3:52 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0		55.00
57.00	05700	CT SCAN	0	0		57.00
57.01	03630	ULTRA SOUND	0	0		57.01
58.00	05800	MRI	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	75	0		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	16	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	9,038		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03020	OTHER ANCILLARY	0	0		76.00
76.01	03140	CARDIAC REHAB	0	0		76.01
76.02	03070	WOMEN'S CENTER	0	0		76.02
76.03	03330	ENDOSCOPY	0	0		76.03
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0		77.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
90.01	09001	OUTPATIENT	0	0		90.01
90.02	09002	NEUROPSYCHOLOGY	0	0		90.02
91.00	09100	EMERGENCY	0	0		91.00
91.01	09101	SHORT STAY	0	0		91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	91	9,038		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	91	9,038		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 15-0059 | Component CCN: 15-T059 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part II | Date/Time Prepared: 5/25/2023 3:52 pm

Title XVIII | Subprovider - IRF | 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	2,820,224	108,539,393	0.025983	155,401	4,038	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	756,749	15,343,816	0.049319	38,881	1,918	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	399,416	10,084,603	0.039607	13,018	516	55.00
57.00	05700	CT SCAN	8,552	25,441,327	0.000336	65,548	22	57.00
57.01	03630	ULTRA SOUND	4,666	10,902,828	0.000428	15,540	7	57.01
58.00	05800	MRI	6,709	7,521,588	0.000892	14,145	13	58.00
59.00	05900	CARDIAC CATHETERIZATION	140,364	24,937,135	0.005629	7,851	44	59.00
60.00	06000	LABORATORY	875,448	70,225,085	0.012466	696,217	8,679	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	138,068	1,849,297	0.074660	19,621	1,465	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	99,883	8,298,164	0.012037	186,792	2,248	65.00
66.00	06600	PHYSICAL THERAPY	317,705	32,044,326	0.009915	2,544,825	25,232	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	367,111	11,289,231	0.032519	24,824	807	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	451,577	50,177,833	0.009000	587,895	5,291	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	73,828	28,998,810	0.002546	48,411	123	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	646,178	63,660,289	0.010150	527,263	5,352	73.00
74.00	07400	RENAL DIALYSIS	53,119	923,839	0.057498	136,992	7,877	74.00
76.00	03020	OTHER ANCILLARY	0	0	0.000000	0	0	76.00
76.01	03140	CARDIAC REHAB	605,824	15,836,701	0.038254	5,131	196	76.01
76.02	03070	WOMEN'S CENTER	505,595	8,697,783	0.058129	4,203	244	76.02
76.03	03330	ENDOSCOPY	0	0	0.000000	0	0	76.03
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0.000000	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	135,714	6,062,170	0.022387	163	4	90.00
90.01	09001	OUTPATIENT	203,069	7,901,422	0.025700	21,089	542	90.01
90.02	09002	NEUROPSYCHOLOGY	94,882	2,715,354	0.034943	0	0	90.02
91.00	09100	EMERGENCY	1,379,419	72,690,453	0.018977	42,933	815	91.00
91.01	09101	SHORT STAY	0	0	0.000000	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	7,764,717	0.000000	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	10,084,100	591,906,164		5,156,743	65,433	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0059 | Component CCN: 15-T059 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part IV Date/Time Prepared: 5/25/2023 3:52 pm

Title XVIII | Subprovider - IRF | 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
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
57.01	03630	ULTRA SOUND	0	0	0	0	0	57.01
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	391,375	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020	OTHER ANCILLARY	0	0	0	0	0	76.00
76.01	03140	CARDIAC REHAB	0	0	0	0	0	76.01
76.02	03070	WOMEN'S CENTER	0	0	0	0	0	76.02
76.03	03330	ENDOSCOPY	0	0	0	0	0	76.03
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OUTPATIENT	0	0	0	0	0	90.01
90.02	09002	NEUROPSYCHOLOGY	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
91.01	09101	SHORT STAY	0	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	0	391,375	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0059 | Component CCN: 15-T059 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part IV | Date/Time Prepared: 5/25/2023 3:52 pm

Title XVIII | Subprovider - IRF | 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	108,539,393	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	15,343,816	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	10,084,603	0.000000	55.00
57.00	05700	CT SCAN	0	0	0	25,441,327	0.000000	57.00
57.01	03630	ULTRA SOUND	0	0	0	10,902,828	0.000000	57.01
58.00	05800	MRI	0	0	0	7,521,588	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	24,937,135	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	70,225,085	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0.000000	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	1,849,297	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	8,298,164	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	32,044,326	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	11,289,231	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	50,177,833	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	28,998,810	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	391,375	391,375	63,660,289	0.006148	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	923,839	0.000000	74.00
76.00	03020	OTHER ANCILLARY	0	0	0	0	0.000000	76.00
76.01	03140	CARDIAC REHAB	0	0	0	15,836,701	0.000000	76.01
76.02	03070	WOMEN'S CENTER	0	0	0	8,697,783	0.000000	76.02
76.03	03330	ENDOSCOPY	0	0	0	0	0.000000	76.03
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0.000000	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	6,062,170	0.000000	90.00
90.01	09001	OUTPATIENT	0	0	0	7,901,422	0.000000	90.01
90.02	09002	NEUROPSYCHOLOGY	0	0	0	2,715,354	0.000000	90.02
91.00	09100	EMERGENCY	0	0	0	72,690,453	0.000000	91.00
91.01	09101	SHORT STAY	0	0	0	0	0.000000	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	7,764,717	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	391,375	391,375	591,906,164		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0059 | Component CCN: 15-T059 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part IV Date/Time Prepared: 5/25/2023 3:52 pm

Title XVIII | Subprovider - IRF | 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	155,401	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	38,881	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	13,018	0	0	0	55.00
57.00	05700	CT SCAN	0.000000	65,548	0	0	0	57.00
57.01	03630	ULTRA SOUND	0.000000	15,540	0	0	0	57.01
58.00	05800	MRI	0.000000	14,145	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	7,851	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	696,217	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	19,621	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	186,792	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	2,544,825	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	24,824	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	587,895	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	48,411	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.006148	527,263	3,242	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	136,992	0	0	0	74.00
76.00	03020	OTHER ANCILLARY	0.000000	0	0	0	0	76.00
76.01	03140	CARDIAC REHAB	0.000000	5,131	0	118	0	76.01
76.02	03070	WOMEN'S CENTER	0.000000	4,203	0	0	0	76.02
76.03	03330	ENDOSCOPY	0.000000	0	0	0	0	76.03
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0.000000	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	163	0	0	0	90.00
90.01	09001	OUTPATIENT	0.000000	21,089	0	0	0	90.01
90.02	09002	NEUROPSYCHOLOGY	0.000000	0	0	0	0	90.02
91.00	09100	EMERGENCY	0.000000	42,933	0	0	0	91.00
91.01	09101	SHORT STAY	0.000000	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		5,156,743	3,242	118	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-0059 | Component CCN: 15-T059 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part V | Date/Time Prepared: 5/25/2023 3:52 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.137905	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.339887	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.200532	0	0	0	0	55.00
57.00	05700	CT SCAN	0.033244	0	0	0	0	57.00
57.01	03630	ULTRA SOUND	0.057989	0	0	0	0	57.01
58.00	05800	MRI	0.078587	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.064630	0	0	0	0	59.00
60.00	06000	LABORATORY	0.194261	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.453936	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.348235	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.275715	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.133569	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.217672	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.375760	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.415696	0	0	233	0	73.00
74.00	07400	RENAL DIALYSIS	0.531839	0	0	0	0	74.00
76.00	03020	OTHER ANCILLARY	0.000000	0	0	0	0	76.00
76.01	03140	CARDIAC REHAB	0.145272	118	0	0	17	76.01
76.02	03070	WOMEN'S CENTER	0.182911	0	0	0	0	76.02
76.03	03330	ENDOSCOPY	0.000000	0	0	0	0	76.03
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0.000000	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.147523	0	0	0	0	90.00
90.01	09001	OUTPATIENT	0.225875	0	0	0	0	90.01
90.02	09002	NEUROPSYCHOLOGY	0.192312	0	0	0	0	90.02
91.00	09100	EMERGENCY	0.337981	0	0	0	0	91.00
91.01	09101	SHORT STAY	0.000000	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.730429	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000		0			95.00
200.00		Subtotal (see instructions)		118	0	233	17	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		118	0	233	17	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-0059 | Component CCN: 15-T059 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part V | Date/Time Prepared: 5/25/2023 3:52 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0		55.00
57.00	05700	CT SCAN	0	0		57.00
57.01	03630	ULTRA SOUND	0	0		57.01
58.00	05800	MRI	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	0	0		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	97		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03020	OTHER ANCILLARY	0	0		76.00
76.01	03140	CARDIAC REHAB	0	0		76.01
76.02	03070	WOMEN'S CENTER	0	0		76.02
76.03	03330	ENDOSCOPY	0	0		76.03
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0		77.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
90.01	09001	OUTPATIENT	0	0		90.01
90.02	09002	NEUROPSYCHOLOGY	0	0		90.02
91.00	09100	EMERGENCY	0	0		91.00
91.01	09101	SHORT STAY	0	0		91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	0	97		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	97		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0059 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-1 | Date/Time Prepared: 5/25/2023 3:52 pm

Title XVIII | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	15,413	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	15,413	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)	12,716	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)	3,873	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)	32,412,257	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)	32,412,257	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)	32,412,257	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	2,102.92	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	8,144,609	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	8,144,609	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0059 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-1 | Date/Time Prepared: 5/25/2023 3:52 pm

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)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	7,163,643	3,181	2,252.01	878	1,977,265	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)	7,176,204	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)	17,298,078	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	1,734,938	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	496,937	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	2,231,875	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	15,066,203	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
55.01	Permanent adjustment amount per discharge	0.00	55.01
55.02	Adjustment amount per discharge (contractor use only)	0.00	55.02
56.00	Target amount (line 54 x sum of lines 55, 55.01, and 55.02)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)	0.00	59.00
60.00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)	0.00	60.00
61.00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	2,697	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,102.92	88.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0059	Period: From 01/01/2022 To 12/31/2022	Worksheet D-1 Date/Time Prepared: 5/25/2023 3:52 pm
	Title XVIII	Hospital	PPS

	Cost Center Description		
		1.00	
89.00	Observation bed cost (line 87 x line 88) (see instructions)	5,671,575	89.00

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	5,943,625	32,412,257	0.183376	5,671,575	1,040,031	90.00
91.00	Nursing Program cost	0	32,412,257	0.000000	5,671,575	0	91.00
92.00	Allied health cost	0	32,412,257	0.000000	5,671,575	0	92.00
93.00	All other Medical Education	0	32,412,257	0.000000	5,671,575	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0059 Component CCN: 15-T059	Period: From 01/01/2022 To 12/31/2022	Worksheet D-1 Date/Time Prepared: 5/25/2023 3:52 pm
	Title XVIII	Subprovider - IRF	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)	3,987	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,987	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)	3,987	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)	2,096	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)	5,320,066	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)	5,320,066	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	5,320,066	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)	1,334.35	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,796,798	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	2,796,798	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0059 | Component CCN: 15-T059 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-1 | Date/Time Prepared: 5/25/2023 3:52 pm

Title XVIII | Subprovider - IRF | 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)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	1,415,131	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)	4,211,929	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)	527,731	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	68,675	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	596,406	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	3,615,523	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

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0059 Component CCN: 15-T059	Period: From 01/01/2022 To 12/31/2022	Worksheet D-1 Date/Time Prepared: 5/25/2023 3:52 pm
	Title XVIII	Subprovider - IRF	PPS

	Cost Center Description	1.00	
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

	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	1,003,838	5,320,066	0.188689	0	0	90.00
91.00	Nursing Program cost	0	5,320,066	0.000000	0	0	91.00
92.00	Allied health cost	0	5,320,066	0.000000	0	0	92.00
93.00	All other Medical Education	0	5,320,066	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0059 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-1 | Date/Time Prepared: 5/25/2023 3:52 pm

Title XIX | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	15,413	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	15,413	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)	12,716	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)	466	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	1,518	15.00
16.00	Nursery days (title V or XIX only)	141	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)	32,412,257	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)	32,412,257	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)	32,412,257	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	2,102.92	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	979,961	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)	979,961	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0059 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-1 | Date/Time Prepared: 5/25/2023 3:52 pm

Title XIX | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	1,518	0.00	141	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	7,163,643	3,181	2,252.01	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	394,326	48.00
48.01	Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)	0	48.01
49.00	Total Program inpatient costs (sum of lines 41 through 48.01)(see instructions)	1,374,287	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
55.01	Permanent adjustment amount per discharge	0.00	55.01
55.02	Adjustment amount per discharge (contractor use only)	0.00	55.02
56.00	Target amount (line 54 x sum of lines 55, 55.01, and 55.02)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)	0.00	59.00
60.00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)	0.00	60.00
61.00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	2,697	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,102.92	88.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0059	Period: From 01/01/2022 To 12/31/2022	Worksheet D-1 Date/Time Prepared: 5/25/2023 3:52 pm
	Title XIX	Hospital	Cost

	Cost Center Description		
		1.00	
89.00	Observation bed cost (line 87 x line 88) (see instructions)	5,671,575	89.00

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	5,943,625	32,412,257	0.183376	5,671,575	1,040,031	90.00
91.00	Nursing Program cost	0	32,412,257	0.000000	5,671,575	0	91.00
92.00	Allied health cost	0	32,412,257	0.000000	5,671,575	0	92.00
93.00	All other Medical Education	0	32,412,257	0.000000	5,671,575	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0059 Component CCN: 15-T059	Period: From 01/01/2022 To 12/31/2022	Worksheet D-1 Date/Time Prepared: 5/25/2023 3:52 pm
	Title XIX	Subprovider - IRF	Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,987	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,987	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)	3,987	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)	10	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	1,518	15.00
16.00	Nursery days (title V or XIX only)	141	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)	5,320,066	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)	5,320,066	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	5,320,066	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)	1,334.35	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	13,344	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)	13,344	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0059 | Component CCN: 15-T059 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-1 | Date/Time Prepared: 5/25/2023 3:52 pm

Title XIX | Subprovider - IRF | Cost

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	36,192	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)	49,536	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
55.01	Permanent adjustment amount per discharge	0.00	55.01
55.02	Adjustment amount per discharge (contractor use only)	0.00	55.02
56.00	Target amount (line 54 x sum of lines 55, 55.01, and 55.02)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)	0.00	59.00
60.00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)	0.00	60.00
61.00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0059 Component CCN: 15-T059	Period: From 01/01/2022 To 12/31/2022	Worksheet D-1 Date/Time Prepared: 5/25/2023 3:52 pm
	Title XIX	Subprovider - IRF	Cost

	Cost Center Description		
		1.00	
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

	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	1,003,838	5,320,066	0.188689	0	0	90.00
91.00	Nursing Program cost	0	5,320,066	0.000000	0	0	91.00
92.00	Allied health cost	0	5,320,066	0.000000	0	0	92.00
93.00	All other Medical Education	0	5,320,066	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0059 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-3 | Date/Time Prepared: 5/25/2023 3:52 pm

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		8,360,541		30.00
31.00	03100	INTENSIVE CARE UNIT		3,137,922		31.00
41.00	04100	SUBPROVIDER - IRF		652,603		41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.137905	3,965,413	546,850	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.339887	792,312	269,297	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.200532	107,625	21,582	55.00
57.00	05700	CT SCAN	0.033244	1,512,935	50,296	57.00
57.01	03630	ULTRA SOUND	0.057989	346,738	20,107	57.01
58.00	05800	MRI	0.078587	188,561	14,818	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.064630	2,232,233	144,269	59.00
60.00	06000	LABORATORY	0.194261	5,159,198	1,002,231	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.453936	134,857	61,216	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.348235	1,981,694	690,095	65.00
66.00	06600	PHYSICAL THERAPY	0.275715	1,068,032	294,472	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.133569	886,148	118,362	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.217672	4,111,650	894,991	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.375760	1,468,240	551,706	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.415696	3,425,835	1,424,106	73.00
74.00	07400	RENAL DIALYSIS	0.531839	222,841	118,516	74.00
76.00	03020	OTHER ANCILLARY	0.000000	0	0	76.00
76.01	03140	CARDIAC REHAB	0.145272	155,729	22,623	76.01
76.02	03070	WOMEN'S CENTER	0.182911	77,586	14,191	76.02
76.03	03330	ENDOSCOPY	0.000000	0	0	76.03
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0.000000	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.147523	8,606	1,270	90.00
90.01	09001	OUTPATIENT	0.225875	70,038	15,820	90.01
90.02	09002	NEUROPSYCHOLOGY	0.192312	0	0	90.02
91.00	09100	EMERGENCY	0.337981	2,028,893	685,727	91.00
91.01	09101	SHORT STAY	0.000000	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.730429	292,512	213,659	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		30,237,676	7,176,204	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)		30,237,676		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0059 | Component CCN: 15-T059 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-3 | Date/Time Prepared: 5/25/2023 3:52 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
41.00	04100	SUBPROVIDER - IRF		3,403,427		41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.137905	155,401	21,431	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.339887	38,881	13,215	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.200532	13,018	2,611	55.00
57.00	05700	CT SCAN	0.033244	65,548	2,179	57.00
57.01	03630	ULTRA SOUND	0.057989	15,540	901	57.01
58.00	05800	MRI	0.078587	14,145	1,112	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.064630	7,851	507	59.00
60.00	06000	LABORATORY	0.194261	696,217	135,248	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.453936	19,621	8,907	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.348235	186,792	65,048	65.00
66.00	06600	PHYSICAL THERAPY	0.275715	2,544,825	701,646	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.133569	24,824	3,316	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.217672	587,895	127,968	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.375760	48,411	18,191	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.415696	527,263	219,181	73.00
74.00	07400	RENAL DIALYSIS	0.531839	136,992	72,858	74.00
76.00	03020	OTHER ANCILLARY	0.000000	0	0	76.00
76.01	03140	CARDIAC REHAB	0.145272	5,131	745	76.01
76.02	03070	WOMEN'S CENTER	0.182911	4,203	769	76.02
76.03	03330	ENDOSCOPY	0.000000	0	0	76.03
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0.000000	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.147523	163	24	90.00
90.01	09001	OUTPATIENT	0.225875	21,089	4,763	90.01
90.02	09002	NEUROPSYCHOLOGY	0.192312	0	0	90.02
91.00	09100	EMERGENCY	0.337981	42,933	14,511	91.00
91.01	09101	SHORT STAY	0.000000	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.730429	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		5,156,743	1,415,131	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)		5,156,743		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0059 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-3 | Date/Time Prepared: 5/25/2023 3:52 pm

Title XIX | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		1,383,350		30.00
31.00	03100	INTENSIVE CARE UNIT		259,536		31.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
43.00	04300	NURSERY		0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.137905	479,738	66,158	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.339887	27,136	9,223	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.200532	0	0	55.00
57.00	05700	CT SCAN	0.033244	80,035	2,661	57.00
57.01	03630	ULTRA SOUND	0.057989	20,588	1,194	57.01
58.00	05800	MRI	0.078587	7,902	621	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.064630	117,693	7,606	59.00
60.00	06000	LABORATORY	0.194261	374,426	72,736	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.453936	37,552	17,046	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.348235	110,628	38,525	65.00
66.00	06600	PHYSICAL THERAPY	0.275715	27,504	7,583	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.133569	46,456	6,205	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.217672	943	205	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.375760	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.415696	271,296	112,777	73.00
74.00	07400	RENAL DIALYSIS	0.531839	0	0	74.00
76.00	03020	OTHER ANCILLARY	0.000000	0	0	76.00
76.01	03140	CARDIAC REHAB	0.145272	8,219	1,194	76.01
76.02	03070	WOMEN'S CENTER	0.182911	0	0	76.02
76.03	03330	ENDOSCOPY	0.000000	0	0	76.03
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0.000000	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.147523	0	0	90.00
90.01	09001	OUTPATIENT	0.225875	15,644	3,534	90.01
90.02	09002	NEUROPSYCHOLOGY	0.192312	0	0	90.02
91.00	09100	EMERGENCY	0.337981	139,233	47,058	91.00
91.01	09101	SHORT STAY	0.000000	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.730429	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,764,993	394,326	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		1,764,993		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0059 | Component CCN: 15-T059 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-3 | Date/Time Prepared: 5/25/2023 3:52 pm

Title XIX | Subprovider - IRF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
41.00	04100	SUBPROVIDER - IRF		906,395		41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.137905	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.339887	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.200532	0	0	55.00
57.00	05700	CT SCAN	0.033244	0	0	57.00
57.01	03630	ULTRA SOUND	0.057989	0	0	57.01
58.00	05800	MRI	0.078587	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.064630	0	0	59.00
60.00	06000	LABORATORY	0.194261	6,800	1,321	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.453936	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.348235	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.275715	70,268	19,374	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.133569	13,057	1,744	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.217672	63,182	13,753	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.375760	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.415696	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.531839	0	0	74.00
76.00	03020	OTHER ANCILLARY	0.000000	0	0	76.00
76.01	03140	CARDIAC REHAB	0.145272	0	0	76.01
76.02	03070	WOMEN'S CENTER	0.182911	0	0	76.02
76.03	03330	ENDOSCOPY	0.000000	0	0	76.03
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0.000000	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.147523	0	0	90.00
90.01	09001	OUTPATIENT	0.225875	0	0	90.01
90.02	09002	NEUROPSYCHOLOGY	0.192312	0	0	90.02
91.00	09100	EMERGENCY	0.337981	0	0	91.00
91.01	09101	SHORT STAY	0.000000	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.730429	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		153,307	36,192	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)		153,307		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0059	Period: From 01/01/2022 To 12/31/2022	Worksheet E Part A Date/Time Prepared: 5/25/2023 3:52 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		
1.00	DRG Amounts Other than Outlier Payments	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	6,653,487	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	2,762,567	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)	0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)	0	1.04
2.00	Outlier payments for discharges. (see instructions)		2.00
2.01	Outlier reconciliation amount	0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)	0	2.02
2.03	Outlier payments for discharges occurring prior to October 1 (see instructions)	256,604	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)	13,200	2.04
3.00	Managed Care Simulated Payments	0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	113.42	4.00
	Indirect Medical Education Adjustment		
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)	0.00	5.00
5.01	FTE cap adjustment for qualifing hospitals under §131 of the CAA 2021 (see instructions)	0.00	5.01
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)	0.00	6.00
6.26	Rural track program FTE cap limitation adjustment after the cap-building window closed under §127 of the CAA 2021 (see instructions)	0.00	6.26
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.	0.00	7.01
7.02	Adjustment (increase or decrease) to the hospital's rural track program FTE limitation(s) for rural track programs with a rural track for Medicare GME affiliated programs in accordance with 413.75(b) and 87 FR 49075 (August 10, 2022) (see instructions)	0.00	7.02
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.	0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)	0.00	8.02
8.21	The amount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (see instructions)	0.00	8.21
9.00	Sum of lines 5 and 5.01, plus line 6, plus lines 6.26 through 6.49, minus lines 7 and 7.01, plus or minus line 7.02, plus/minus line 8, plus lines 8.01 through 8.27 (see instructions)	0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.	0.00	11.00
12.00	Current year allowable FTE (see instructions)	0.00	12.00
13.00	Total allowable FTE count for the prior year.	0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.	0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.	0.00	15.00
16.00	Adjustment for residents in initial years of the program (see instructions)	0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure	0.00	17.00
18.00	Adjusted rolling average FTE count	0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)	0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.000000	21.00
22.00	IME payment adjustment (see instructions)	0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)	0	22.01
	Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA		
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).	0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)	0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)	0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)	0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)	0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)	0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)	0	28.01
29.00	Total IME payment (sum of lines 22 and 28)	0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	0	29.01
	Disproportionate Share Adjustment		
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	1.92	30.00
31.00	Percentage of Medicaid patient days (see instructions)	19.12	31.00
32.00	Sum of lines 30 and 31	21.04	32.00
33.00	Allowable disproportionate share percentage (see instructions)	6.58	33.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0059	Period: From 01/01/2022 To 12/31/2022	Worksheet E Part A Date/Time Prepared: 5/25/2023 3:52 pm
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			1.00	
34.00	Disproportionate share adjustment (see instructions)		154,894	34.00
		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	Uncompensated Care Payment Adjustment			
35.00	Total uncompensated care amount (see instructions)	0	0	35.00
35.01	Factor 3 (see instructions)	0.000000000	0.000000000	35.01
35.02	Hospital UCP, including supplemental UCP (If line 34 is zero, enter zero on this line) (see instructions)	1,478,064	1,468,768	35.02
35.03	Pro rata share of the hospital UCP, including supplemental UCP (see instructions)	1,105,511	370,210	35.03
36.00	Total UCP adjustment (sum of columns 1 and 2 on line 35.03)	1,475,721		36.00
	Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)			
40.00	Total Medicare discharges (see instructions)	0		40.00
41.00	Total ESRD Medicare discharges (see instructions)	0		41.00
41.01	Total ESRD Medicare covered and paid discharges (see instructions)	0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days (see instructions)	0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00
47.00	Subtotal (see instructions)	11,316,473		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	0		48.00
			Amount	
			1.00	
49.00	Total payment for inpatient operating costs (see instructions)		11,316,473	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		842,648	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).		0	52.00
53.00	Nursing and Allied Health Managed Care payment		44,597	53.00
54.00	Special add-on payments for new technologies		86,994	54.00
54.01	Islet isolation add-on payment		0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0	55.00
55.01	Cellular therapy acquisition cost (see instructions)		0	55.01
56.00	Cost of physicians' services in a teaching hospital (see intructions)		0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		21,062	58.00
59.00	Total (sum of amounts on lines 49 through 58)		12,311,774	59.00
60.00	Primary payer payments		4,403	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		12,307,371	61.00
62.00	Deductibles billed to program beneficiaries		1,130,348	62.00
63.00	Coinsurance billed to program beneficiaries		5,446	63.00
64.00	Allowable bad debts (see instructions)		34,015	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		22,110	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		11,193,687	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)		0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	70.00
70.50	Rural Community Hospital Demonstration Project (§410A Demonstration) adjustment (see instructions)		0	70.50
70.75	N95 respirator payment adjustment amount (see instructions)		0	70.75
70.87	Demonstration payment adjustment amount before sequestration		0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)		0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)			70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		0	70.91
70.92	Bundled Model 1 discount amount (see instructions)		0	70.92
70.93	HVBP payment adjustment amount (see instructions)		0	70.93
70.94	HRR adjustment amount (see instructions)		-45,816	70.94
70.95	Recovery of accelerated depreciation		0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0059 | Period: From 01/01/2022 To 12/31/2022 | Worksheet E Part A | Date/Time Prepared: 5/25/2023 3:52 pm

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		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		88,106	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		11,059,765	71.00
71.01	Sequestration adjustment (see instructions)		139,353	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
71.03	Sequestration adjustment-PARHM or CHART pass-throughs			71.03
72.00	Interim payments		10,353,661	72.00
72.01	Interim payments-PARHM or CHART			72.01
73.00	Tentative settlement (for contractor use only)		0	73.00
73.01	Tentative settlement-PARHM or CHART (for contractor use only)			73.01
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		566,751	74.00
74.01	Balance due provider/program-PARHM or CHART (see instructions)			74.01
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		151,523	75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00

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

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 15-0059 | Period: From 01/01/2022 To 12/31/2022 | Worksheet E Part A Exhibit 4 | Date/Time Prepared: 5/25/2023 3:52 pm

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		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	6,653,487	0	6,653,487		6,653,487	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	2,762,567	0		2,762,567	2,762,567	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00						2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	256,604	0	256,604		256,604	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	13,200	0		13,200	13,200	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	0	4.00
	Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0	9.01
	Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0658	0.0658	0.0658	0.0658		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	154,894	0	109,450	45,444	154,894	11.00
11.01	Uncompensated care payments	36.00	1,475,721	0	1,105,511	370,210	1,475,721	11.01
	Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	11,316,473	0	8,125,052	3,191,421	11,316,473	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	11,316,473	0	8,125,052	3,191,421	11,316,473	15.00

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 15-0059 | Period: From 01/01/2022 To 12/31/2022 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 5/25/2023 3:52 pm

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		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	842,648	0	624,244	218,404	842,648	16.00
17.00	Special add-on payments for new technologies	54.00	86,994	0	70,720	16,274	86,994	17.00
17.01	Net organ aquisition cost							17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			0	8,820,016	3,426,099	12,246,115	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	705,274	0	500,371	204,903	705,274	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	106,695	0	102,107	4,588	106,695	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0435	0.0435	0.0435	0.0435		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	30,679	0	21,766	8,913	30,679	25.00
26.00	Total prospective capital payments (see instructions)	12.00	842,648	0	624,244	218,404	842,648	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.000000	0.000000		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			0		0	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				0	0	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 15-0059 | Period: From 01/01/2022 To 12/31/2022 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/25/2023 3:52 pm

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		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	6,653,487	6,653,487		6,653,487	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	2,762,567		2,762,567	2,762,567	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00					2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	256,604	256,604		256,604	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	13,200		13,200	13,200	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	4.00
	Indirect Medical Education Adjustment						
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA						
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
	Disproportionate Share Adjustment						
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0658	0.0658	0.0658		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	154,894	109,450	45,444	154,894	11.00
11.01	Uncompensated care payments	36.00	1,475,721	1,105,511	370,210	1,475,721	11.01
	Additional payment for high percentage of ESRD beneficiary discharges						
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	11,316,473	8,125,052	3,191,421	11,316,473	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	11,316,473	8,125,052	3,191,421	11,316,473	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	842,648	624,244	218,404	842,648	16.00
17.00	Special add-on payments for new technologies	54.00	86,994	70,720	16,274	86,994	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			8,820,016	3,426,099	12,246,115	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 15-0059 | Period: From 01/01/2022 To 12/31/2022 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/25/2023 3:52 pm

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		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	705,274	500,371	204,903	705,274	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	106,695	102,107	4,588	106,695	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0435	0.0435	0.0435		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	30,679	21,766	8,913	30,679	25.00
26.00	Total prospective capital payments (see instructions)	12.00	842,648	624,244	218,404	842,648	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	0	0		0	28.00
29.00	Low volume adjustment on or after October 1	70.97	0		0	0	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	0	0	0	0	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	-45,816	-9,413	-36,403	-45,816	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		88,106	0	88,106	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Y				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0059	Period: From 01/01/2022 To 12/31/2022	Worksheet E Part B Date/Time Prepared: 5/25/2023 3:52 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	9,129	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	22,129,770	2.00
3.00	OPPS payments	18,087,530	3.00
4.00	Outlier payment (see instructions)	232,775	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	118,150	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	9,129	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	22,199	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	22,199	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	22,199	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	13,070	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	9,129	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	18,438,455	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	61	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	3,233,714	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	15,213,809	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	15,213,809	30.00
31.00	Primary payer payments	5,258	31.00
32.00	Subtotal (line 30 minus line 31)	15,208,551	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	32,005	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	20,803	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	36.00
37.00	Subtotal (see instructions)	15,229,354	37.00
38.00	MSP-LCC reconciliation amount from PS&R	-92	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.75	N95 respirator payment adjustment amount (see instructions)	0	39.75
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	15,229,446	40.00
40.01	Sequestration adjustment (see instructions)	191,891	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
40.03	Sequestration adjustment-PARHM or CHART pass-throughs		40.03
41.00	Interim payments	15,021,232	41.00
41.01	Interim payments-PARHM or CHART		41.01
42.00	Tentative settlement (for contractors use only)	0	42.00
42.01	Tentative settlement-PARHM or CHART (for contractor use only)		42.01
43.00	Balance due provider/program (see instructions)	16,323	43.00
43.01	Balance due provider/program-PARHM (see instructions)		43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0059	Period: From 01/01/2022 To 12/31/2022	Worksheet E Part B Date/Time Prepared: 5/25/2023 3:52 pm
	Title XVIII	Hospital	PPS

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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0059 Component CCN: 15-T059	Period: From 01/01/2022 To 12/31/2022	Worksheet E Part B Date/Time Prepared: 5/25/2023 3:52 pm
	Title XVIII	Subprovider - IRF	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	97	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	17	2.00
3.00	OPPS payments	40	3.00
4.00	Outlier payment (see instructions)	0	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	97	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	233	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	233	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	233	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	136	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	97	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	40	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	0	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	137	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	137	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	137	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	36.00
37.00	Subtotal (see instructions)	137	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.75	N95 respirator payment adjustment amount (see instructions)	0	39.75
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	137	40.00
40.01	Sequestration adjustment (see instructions)	1	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
40.03	Sequestration adjustment-PARHM or CHART pass-throughs		40.03
41.00	Interim payments	108	41.00
41.01	Interim payments-PARHM or CHART		41.01
42.00	Tentative settlement (for contractors use only)	0	42.00
42.01	Tentative settlement-PARHM or CHART (for contractor use only)		42.01
43.00	Balance due provider/program (see instructions)	28	43.00
43.01	Balance due provider/program-PARHM (see instructions)		43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0059 Component CCN: 15-T059	Period: From 01/01/2022 To 12/31/2022	Worksheet E Part B Date/Time Prepared: 5/25/2023 3:52 pm
	Title XVIII	Subprovider - IRF	PPS

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-0059 | Period: From 01/01/2022 To 12/31/2022 | Worksheet E-1 Part I | Date/Time Prepared: 5/25/2023 3:52 pm

Title XVIII | Hospital | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		10,278,083		14,886,111	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	12/21/2022	75,578	12/21/2022	135,121	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		75,578		135,121	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)		10,353,661		15,021,232	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		566,751		16,323	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		10,920,412		15,037,555	7.00

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-0059 | Component CCN: 15-T059 | Period: From 01/01/2022 To 12/31/2022 | Worksheet E-1 Part I | Date/Time Prepared: 5/25/2023 3:52 pm

Title XVIII | Subprovider - IRF | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		4,226,617		108	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		4,226,617		108	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		50,092		28	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		4,276,709		136	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-0059	Period: From 01/01/2022 To 12/31/2022	Worksheet E-1 Part II Date/Time Prepared: 5/25/2023 3:52 pm
	Title XVIII	Hospital	PPS

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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0059 Component CCN: 15-T059	Period: From 01/01/2022 To 12/31/2022	Worksheet E-3 Part III Date/Time Prepared: 5/25/2023 3:52 pm
	Title XVIII	Subprovider - IRF	PPS

		1.00	
	PART III - MEDICARE PART A SERVICES - IRF PPS		
1.00	Net Federal PPS Payment (see instructions)	4,094,847	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)	0.0109	2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)	142,091	3.00
4.00	Outlier Payments	154,827	4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)	0.00	5.00
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00	5.01
6.00	New Teaching program adjustment. (see instructions)	0.00	6.00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)	0.00	7.00
8.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)	0.00	8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)	0.00	9.00
10.00	Average Daily Census (see instructions)	10.923288	10.00
11.00	Teaching Adjustment Factor (see instructions)	0.000000	11.00
12.00	Teaching Adjustment (see instructions)	0	12.00
13.00	Total PPS Payment (see instructions)	4,391,765	13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)	0	14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)		15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)	0	16.00
17.00	Subtotal (see instructions)	4,391,765	17.00
18.00	Primary payer payments	0	18.00
19.00	Subtotal (line 17 less line 18).	4,391,765	19.00
20.00	Deductibles	49,720	20.00
21.00	Subtotal (line 19 minus line 20)	4,342,045	21.00
22.00	Coinsurance	14,004	22.00
23.00	Subtotal (line 21 minus line 22)	4,328,041	23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	0	24.00
25.00	Adjusted reimbursable bad debts (see instructions)	0	25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	26.00
27.00	Subtotal (sum of lines 23 and 25)	4,328,041	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	28.00
29.00	Other pass through costs (see instructions)	3,242	29.00
30.00	Outlier payments reconciliation	0	30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	31.00
31.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	31.50
31.98	Recovery of accelerated depreciation.	0	31.98
31.99	Demonstration payment adjustment amount before sequestration	0	31.99
32.00	Total amount payable to the provider (see instructions)	4,331,283	32.00
32.01	Sequestration adjustment (see instructions)	54,574	32.01
32.02	Demonstration payment adjustment amount after sequestration	0	32.02
33.00	Interim payments	4,226,617	33.00
34.00	Tentative settlement (for contractor use only)	0	34.00
35.00	Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)	50,092	35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	36.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4	154,827	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	0.00	52.00
53.00	Time Value of Money (see instructions)	0	53.00
	FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING BEFORE THE END OF THE COVID-19 PHE		
99.00	Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020.	0.000000	99.00
99.01	Calculated Teaching Adjustment Factor for the current year. (see instructions)	0.000000	99.01

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0059	Period: From 01/01/2022 To 12/31/2022	Worksheet E-3 Part VII Date/Time Prepared: 5/25/2023 3:52 pm
	Title XIX	Hospital	Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	1,374,287		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)	1,374,287	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)	1,374,287	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	1,642,886		8.00
9.00	Ancillary service charges	1,764,993	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)	3,407,879	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)	3,407,879	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	2,033,592	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)	1,374,287	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)	1,374,287	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)	1,374,287	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)	1,374,287	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	1,374,287	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)	1,374,287	0	40.00
41.00	Interim payments	1,562,894	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	-188,607	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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0059 Component CCN: 15-T059	Period: From 01/01/2022 To 12/31/2022	Worksheet E-3 Part VII Date/Time Prepared: 5/25/2023 3:52 pm
	Title XIX	Subprovider - IRF	Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	49,536		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)	49,536	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)	49,536	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	906,395		8.00
9.00	Ancillary service charges	153,307	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)	1,059,702	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)	1,059,702	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	1,010,166	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)	49,536	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)	49,536	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)	49,536	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)	49,536	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	49,536	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)	49,536	0	40.00
41.00	Interim payments	487,463	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	-437,927	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

OUTLIER RECONCILIATION AT TENTATIVE SETTLEMENT	Provider CCN: 15-0059	Period: From 01/01/2022 To 12/31/2022	Worksheet E-5 Date/Time Prepared: 5/25/2023 3:52 pm
	Title XVIII		PPS

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

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

Provider CCN: 15-0059 | Period: From 01/01/2022 To 12/31/2022 | Worksheet G | Date/Time Prepared: 5/25/2023 3:52 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	4,387,097	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	97,565,936	0	0	0	4.00
5.00	Other receivable	13,791,092	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-63,457,237	0	0	0	6.00
7.00	Inventory	7,324,183	0	0	0	7.00
8.00	Prepaid expenses	3,123,585	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	62,734,656	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	16,050,414	0	0	0	12.00
13.00	Land improvements	3,330,308	0	0	0	13.00
14.00	Accumulated depreciation	-4,232,212	0	0	0	14.00
15.00	Buildings	166,686,771	0	0	0	15.00
16.00	Accumulated depreciation	-87,200,599	0	0	0	16.00
17.00	Leasehold improvements	18,834,183	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	52,683,867	0	0	0	19.00
20.00	Accumulated depreciation	-39,741,687	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	125,643,510	0	0	0	23.00
24.00	Accumulated depreciation	-98,879,439	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)	153,175,116	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	63,352,895	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	79,827	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	63,432,722	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	279,342,494	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	9,613,225	0	0	0	37.00
38.00	Salaries, wages, and fees payable	9,680,512	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	14,089,424	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	129,374,513	0	0	0	43.00
44.00	Other current liabilities	5,905,593	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	168,663,267	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	45,940,185	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	12,734,750	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	58,674,935	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	227,338,202	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	52,004,292				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)	52,004,292	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	279,342,494	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-0059 | Period: From 01/01/2022 To 12/31/2022 | Worksheet G-1 | Date/Time Prepared: 5/25/2023 3:52 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		88,790,859		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-36,786,567				2.00
3.00	Total (sum of line 1 and line 2)		52,004,292		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		52,004,292		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)		52,004,292		0		19.00

		Endowment Fund	Plant Fund		
		6.00	7.00	8.00	
1.00	Fund balances at beginning of period	0		0	1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)				2.00
3.00	Total (sum of line 1 and line 2)	0		0	3.00
4.00	Additions (credit adjustments) (specify)		0		4.00
5.00			0		5.00
6.00			0		6.00
7.00			0		7.00
8.00			0		8.00
9.00			0		9.00
10.00	Total additions (sum of line 4-9)	0		0	10.00
11.00	Subtotal (line 3 plus line 10)	0		0	11.00
12.00	Deductions (debit adjustments) (specify)		0		12.00
13.00			0		13.00
14.00			0		14.00
15.00			0		15.00
16.00			0		16.00
17.00			0		17.00
18.00	Total deductions (sum of lines 12-17)	0		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0	19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 15-0059 | Period: From 01/01/2022 To 12/31/2022 | Worksheet G-2 Parts I & II Date/Time Prepared: 5/25/2023 3:52 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	52,706,429		52,706,429	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF	7,155,923		7,155,923	3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY	0		0	7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	59,862,352		59,862,352	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	13,023,110		13,023,110	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)	13,023,110		13,023,110	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	72,885,462		72,885,462	17.00
18.00	Ancillary services	99,267,095	382,028,911	481,296,006	18.00
19.00	Outpatient services	7,862,955	89,702,684	97,565,639	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	0	0	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER OUTPATIENT	0	58,968,338	58,968,338	27.00
27.01	PROF FEES	0	34,930,777	34,930,777	27.01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	180,015,512	565,630,710	745,646,222	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		277,535,793		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		277,535,793		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-0059 | Period: From 01/01/2022 To 12/31/2022 | Worksheet G-3 | Date/Time Prepared: 5/25/2023 3:52 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	745,646,222	1.00
2.00	Less contractual allowances and discounts on patients' accounts	512,510,479	2.00
3.00	Net patient revenues (line 1 minus line 2)	233,135,743	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	277,535,793	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-44,400,050	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	-8,676,259	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER OPERATING INCOME	13,279,672	24.00
24.01	OTHER OPERATING REVENUE	23,457	24.01
24.02	DSH REVENUE	2,986,613	24.02
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	7,613,483	25.00
26.00	Total (line 5 plus line 25)	-36,786,567	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-36,786,567	29.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 15-0059	Period: From 01/01/2022 To 12/31/2022	Worksheet L Parts I-III Date/Time Prepared: 5/25/2023 3:52 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	705,274	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	106,695	2.00
2.01	Model 4 BPCI Capital DRG outlier payments	0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)	44.30	3.00
4.00	Number of interns & residents (see instructions)	0.00	4.00
5.00	Indirect medical education percentage (see instructions)	0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)	0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	1.92	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	19.12	8.00
9.00	Sum of lines 7 and 8	21.04	9.00
10.00	Allowable disproportionate share percentage (see instructions)	4.35	10.00
11.00	Disproportionate share adjustment (see instructions)	30,679	11.00
12.00	Total prospective capital payments (see instructions)	842,648	12.00
		1.00	
	PART II - PAYMENT UNDER REASONABLE COST		
1.00	Program inpatient routine capital cost (see instructions)	0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)	0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)	0	3.00
4.00	Capital cost payment factor (see instructions)	0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)	0	5.00
		1.00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS		
1.00	Program inpatient capital costs (see instructions)	0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)	0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)	0	3.00
4.00	Applicable exception percentage (see instructions)	0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)	0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)	0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)	0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)	0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)	0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)	0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)	0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)	0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)	0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)	0	14.00
15.00	Current year allowable operating and capital payment (see instructions)	0	15.00
16.00	Current year operating and capital costs (see instructions)	0	16.00
17.00	Current year exception offset amount (see instructions)	0	17.00