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 03-31-2022

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 15-1335	Period: From 07/01/2021 To 06/30/2022	Worksheet S Parts I-III Date/Time Prepared: 11/28/2022 2:22 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 11/28/2022 Time: 2:22 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 or "L" for low.

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 ASCENSION ST. VINCENT DUNN (15-1335) for the cost reporting period beginning 07/01/2021 and ending 06/30/2022 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR		CHECKBOX	ELECTRONIC SIGNATURE STATEMENT	
	1		2		
1	Christopher Hons		Y	I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name	Christopher Hons			2
3	Signatory Title	VP OF FINANCE			3
4	Date	11/28/2022 02:22:05 PM			4

	Cost Center Description	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	213,213	-233,488	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing Bed - SNF	0	33,144	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
200.00	Total	0	246,357	-233,488	0	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1335	Period: From 07/01/2021 To 06/30/2022	Worksheet S-2 Part I Date/Time Prepared: 11/28/2022 2:22 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1616 TWENTY-THIRD STREET	PO Box:			1.00
2.00	City: BEDFORD	State: IN	Zip Code: 47421	County: LAWRENCE	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	ASCENSION ST. VINCENT DUNN	151335	99915	1	07/01/1966	N	O	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	ASCENSION ST. VINCENT DUNN SWING	15Z335	99915		03/03/2012	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									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)	07/01/2021	06/30/2022	20.00
21.00	Type of Control (see instructions)	1		21.00

		1.00	2.00	3.00	
	Inpatient PPS Information				
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N	N		22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N		22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments 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.	N	N	N	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.	2	N		23.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1335 | Period: From 07/01/2021 To 06/30/2022 | Worksheet S-2 Part I | Date/Time Prepared: 11/28/2022 2:22 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.	0	0	0	0	0	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00

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

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

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

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. 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	If line 56 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.				57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.				58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1335 | Period: From 07/01/2021 To 06/30/2022 | Worksheet S-2 Part I Date/Time Prepared: 11/28/2022 2:22 pm

		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 adjustement? Enter "Y" for yes or "N" for no in column 2.	N			60.00

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

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

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

		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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1335 | Period: From 07/01/2021 To 06/30/2022 | Worksheet S-2 Part I | Date/Time Prepared: 11/28/2022 2:22 pm

		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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1335 | Period: From 07/01/2021 To 06/30/2022 | Worksheet S-2 Part I Date/Time Prepared: 11/28/2022 2:22 pm

		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

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.06
	Rural Providers			
105.00	Does this hospital qualify as a CAH?	Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	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.	Y	Y	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1335	Period: From 07/01/2021 To 06/30/2022	Worksheet S-2 Part I Date/Time Prepared: 11/28/2022 2:22 pm

		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 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
	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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	146,032	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.	Y	5.00	122.00
	Transplant Center Information			
125.00	Does this facility operate a 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 center, 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 center, 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 center, 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 center, 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 center, 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 center, 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 center, 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 an 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	15H046	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1335 | Period: From 07/01/2021 To 06/30/2022 | Worksheet S-2 Part I | Date/Time Prepared: 11/28/2022 2:22 pm

	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: ASCENSION ST VINCENT	Contractor's Name: WPS	Contractor's Number: 08001	141.00
142.00	Street: 250 WEST 96TH STREET SUITE 215	PO Box:		142.00
143.00	City: INDIANAPOLIS	State: IN	Zip Code: 46290	143.00

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

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

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

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

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

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

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

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

		1.00	2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N	0	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1335 | Period: From 07/01/2021 To 06/30/2022 | Worksheet S-2 Part II | Date/Time Prepared: 11/28/2022 2:22 pm

			Y/N	Date	
			1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
	COMPLETED BY ALL HOSPITALS				
	Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)		N		1.00
		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y			3.00
		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
			Y/N	Legal Oper.	
			1.00	2.00	
	Approved Educational Activities				
6.00	Column 1: Are costs claimed for a nursing program? Column 2: If yes, is the provider is the legal operator of the program?		N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.		N		7.00
8.00	Were nursing programs and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.		N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.		N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.		N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.		N		11.00
				Y/N	
				1.00	
	Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
	Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N	15.00
		Part A		Part B	
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	10/07/2022	Y	10/07/2022
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N	
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	
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	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1335 | Period: From 07/01/2021 To 06/30/2022 | Worksheet S-2 Part II Date/Time Prepared: 11/28/2022 2:22 pm

		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				N	33.00
	Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				Y	35.00
				Y/N	Date	
				1.00	2.00	
	Home Office Costs					
36.00	Were home office costs claimed on the cost report?			Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			Y		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			N		40.00
		1.00		2.00		
	Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	JILL		HILL		41.00
42.00	Enter the employer/company name of the cost report preparer.	ASCENSION				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	N/A		JILL.HILL1@ASCENSION.ORG		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-1335	Period: From 07/01/2021 To 06/30/2022	Worksheet S-2 Part II Date/Time Prepared: 11/28/2022 2:22 pm

		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	REIMBURSEMENT 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: 15-1335 | Period: From 07/01/2021 To 06/30/2022 | Worksheet S-3 Part I Date/Time Prepared: 11/28/2022 2:22 pm

	Component	Worksheet A Line Number	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	
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	25	9,125	28,488.00	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)		25	9,125	28,488.00	0	7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		25	9,125	28,488.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		25				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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1335 | Period: From 07/01/2021 To 06/30/2022 | Worksheet S-3 Part I Date/Time Prepared: 11/28/2022 2:22 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	
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)	367	34	1,187			1.00
2.00	HMO and other (see instructions)	208	396				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	78	0	80			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	16			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	445	34	1,283			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		33	463			13.00
14.00	Total (see instructions)	445	67	1,746	0.00	73.77	14.00
15.00	CAH visits	6,291	612	27,793			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	73.77	27.00
28.00	Observation Bed Days		0	267			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			32			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	114			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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1335 | Period: From 07/01/2021 To 06/30/2022 | Worksheet S-3 Part I | Date/Time Prepared: 11/28/2022 2:22 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	
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	103	18	471	1.00
2.00	HMO and other (see instructions)			49	168		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	103	18	471	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-1335 | Period: From 07/01/2021 To 06/30/2022 | Worksheet S-10 | Date/Time Prepared: 11/28/2022 2:22 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)	0.392308	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	7,000,773	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	19,256,577	6.00
7.00	Medicaid cost (line 1 times line 6)	7,554,509	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)	553,736	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)	553,736	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)	669,867	260,546	930,413	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	262,794	260,546	523,340	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)	262,794	260,546	523,340	23.00

		1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	1,410,553	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	156,458	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	240,705	27.01
28.00	Non-Medicare bad debt expense (see instructions)	1,169,848	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	543,188	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,066,528	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	1,620,264	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1335 | Period: From 07/01/2021 To 06/30/2022 | Worksheet A | Date/Time Prepared: 11/28/2022 2:22 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		705,286	705,286	0	705,286	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		425,629	425,629	0	425,629	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	60,073	1,616,237	1,676,310	0	1,676,310	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	344,970	7,422,336	7,767,306	0	7,767,306	5.00
7.00	00700	OPERATION OF PLANT	0	1,283,991	1,283,991	0	1,283,991	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	105,380	105,380	0	105,380	8.00
9.00	00900	HOUSEKEEPING	0	444,136	444,136	0	444,136	9.00
10.00	01000	DIETARY	0	540,587	540,587	-421,654	118,933	10.00
11.00	01100	CAFETERIA	0	0	0	421,654	421,654	11.00
13.00	01300	NURSING ADMINISTRATION	159,714	19,601	179,315	0	179,315	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	11,728	11,728	0	11,728	14.00
15.00	01500	PHARMACY	266,883	399,448	666,331	-64	666,267	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	440	440	0	440	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,537,189	281,366	2,818,555	-1,195,211	1,623,344	30.00
43.00	04300	NURSERY	0	0	0	366,602	366,602	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	573,345	330,183	903,528	-71,889	831,639	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	821,439	821,439	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	867,627	125,493	993,120	-1,964	991,156	54.00
60.00	06000	LABORATORY	0	1,831,919	1,831,919	0	1,831,919	60.00
65.00	06500	RESPIRATORY THERAPY	453,356	18,751	472,107	0	472,107	65.00
66.00	06600	PHYSICAL THERAPY	0	454,167	454,167	-98,000	356,167	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	98,000	98,000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	141,649	9,590	151,239	0	151,239	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	39,559	39,559	81,275	120,834	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	29,820	29,820	0	29,820	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	07501	SLEEP DISORDER	0	0	0	0	0	75.01
76.00	03950	SENIOR RENEWAL CENTER	43	403,833	403,876	0	403,876	76.00
76.97	07697	CARDIAC REHABILITATION	63,893	1,761	65,654	0	65,654	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	1,007,129	1,607,882	2,615,011	-204	2,614,807	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	6,475,871	18,109,123	24,584,994	-16	24,584,978	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
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	MARKETING	0	0	0	0	0	194.00
194.01	07951	FOUNDATION	0	0	0	0	0	194.01
194.02	07952	COMMUNITY OUTREACH	0	0	0	0	0	194.02
194.03	07953	WIC	0	0	0	0	0	194.03
194.04	07954	GRANTS	0	-16	-16	16	0	194.04
200.00		TOTAL (SUM OF LINES 118 through 199)	6,475,871	18,109,107	24,584,978	0	24,584,978	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1335 | Period: From 07/01/2021 To 06/30/2022 | Worksheet A | Date/Time Prepared: 11/28/2022 2:22 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	-249,723	455,563		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	425,629		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	55,522	1,731,832		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-1,523,250	6,244,056		5.00
7.00	00700	OPERATION OF PLANT	0	1,283,991		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	105,380		8.00
9.00	00900	HOUSEKEEPING	0	444,136		9.00
10.00	01000	DIETARY	-8,880	110,053		10.00
11.00	01100	CAFETERIA	-65,241	356,413		11.00
13.00	01300	NURSING ADMINISTRATION	-2,609	176,706		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	11,728		14.00
15.00	01500	PHARMACY	0	666,267		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	440		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	1,623,344		30.00
43.00	04300	NURSERY	0	366,602		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	831,639		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	821,439		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-8,150	983,006		54.00
60.00	06000	LABORATORY	0	1,831,919		60.00
65.00	06500	RESPIRATORY THERAPY	0	472,107		65.00
66.00	06600	PHYSICAL THERAPY	0	356,167		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	98,000		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	151,239		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	-35,988	84,846		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	29,820		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0		75.00
75.01	07501	SLEEP DISORDER	0	0		75.01
76.00	03950	SENIOR RENEWAL CENTER	0	403,876		76.00
76.97	07697	CARDIAC REHABILITATION	0	65,654		76.97
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0	2,614,807		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-1,838,319	22,746,659		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
193.00	19300	NONPAID WORKERS	0	0		193.00
194.00	07950	MARKETING	0	0		194.00
194.01	07951	FOUNDATION	0	0		194.01
194.02	07952	COMMUNITY OUTREACH	0	0		194.02
194.03	07953	WIC	0	0		194.03
194.04	07954	GRANTS	0	0		194.04
200.00		TOTAL (SUM OF LINES 118 through 199)	-1,838,319	22,746,659		200.00

RECLASSIFICATIONS | Provider CCN: 15-1335 | Period: From 07/01/2021 To 06/30/2022 | Worksheet A-6 | Date/Time Prepared: 11/28/2022 2:22 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - CAFETERIA					
1.00	CAFETERIA	11.00	0	421,654		1.00
	TOTALS		0	421,654		
	C - NURSERY AND L&D					
1.00	NURSERY	43.00	320,310	46,292		1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	717,713	103,726		2.00
			1,038,023	150,018		
	D - MEDICAL SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	81,291		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
	TOTALS		0	81,291		
	E - THERAPY EXPENSES					
1.00	OCCUPATIONAL THERAPY	67.00		98,000		1.00
			0	98,000		
	F - GRANTS					
1.00	GRANTS	194.04	0	16		1.00
	TOTALS		0	16		
500.00	Grand Total: Increases		1,038,023	750,979		500.00

RECLASSIFICATIONS | Provider CCN: 15-1335 | Period: From 07/01/2021 To 06/30/2022 | Worksheet A-6 | Date/Time Prepared: 11/28/2022 2:22 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - CAFETERIA						
1.00	DIETARY	10.00	0	421,654	0		1.00
	TOTALS		0	421,654			
	C - NURSERY AND L&D						
1.00	ADULTS & PEDIATRICS	30.00	1,038,023	150,018			1.00
2.00							2.00
			1,038,023	150,018			
	D - MEDICAL SUPPLIES						
1.00	PHARMACY	15.00	0	64	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	7,170	0		2.00
3.00	OPERATING ROOM	50.00	0	71,889	0		3.00
4.00	RADIOLOGY-DIAGNOSTIC	54.00	0	1,964	0		4.00
5.00	EMERGENCY	91.00	0	204	0		5.00
	TOTALS		0	81,291			
	E - THERAPY EXPENSES						
1.00	PHYSICAL THERAPY	66.00		98,000			1.00
			0	98,000			
	F - GRANTS						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	16	0		1.00
	TOTALS		0	16			
500.00	Grand Total: Decreases		1,038,023	750,979			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1335 | Period: From 07/01/2021 To 06/30/2022 | Worksheet A-7 Part I | Date/Time Prepared: 11/28/2022 2:22 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	100,000	0	0	0	0	1.00
2.00	Land Improvements	97,759	162,527	0	162,527	0	2.00
3.00	Buildings and Fixtures	6,869,532	399,361	0	399,361	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	2,868,890	0	0	0	0	5.00
6.00	Movable Equipment	5,213,160	257,437	0	257,437	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	15,149,341	819,325	0	819,325	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	15,149,341	819,325	0	819,325	0	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	100,000	0	1.00
2.00	Land Improvements	260,286	0	2.00
3.00	Buildings and Fixtures	7,268,893	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	2,868,890	0	5.00
6.00	Movable Equipment	5,470,597	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	15,968,666	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	15,968,666	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1335 | Period: From 07/01/2021 To 06/30/2022 | Worksheet A-7 Part II | Date/Time Prepared: 11/28/2022 2:22 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	454,463	0	249,723	0	1,100	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	425,629	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	880,092	0	249,723	0	1,100	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	705,286	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	425,629	2.00
3.00	Total (sum of lines 1-2)	0	1,130,915	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1335 | Period: From 07/01/2021 To 06/30/2022 | Worksheet A-7 Part III Date/Time Prepared: 11/28/2022 2:22 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	7,629,179	0	7,629,179	0.477759	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	8,339,487	0	8,339,487	0.522241	0	2.00
3.00	Total (sum of lines 1-2)	15,968,666	0	15,968,666	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	454,463	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	425,629	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	880,092	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	0	0	1,100	0	455,563	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	425,629	2.00
3.00	Total (sum of lines 1-2)	0	0	1,100	0	881,192	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1335 | Period: From 07/01/2021 To 06/30/2022 | Worksheet A-8 | Date/Time Prepared: 11/28/2022 2:22 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)	B	-246,890	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)	B	-9,922	ADMINISTRATIVE & GENERAL	5.00	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	-32,150			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	1,636,083			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-65,241	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	ENTERTAINMENT	A	-68	ADMINISTRATIVE & GENERAL	5.00	0	33.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1335 | Period: From 07/01/2021 To 06/30/2022 | Worksheet A-8 | Date/Time Prepared: 11/28/2022 2:22 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	
33.01	ADVERTISING	A	-252	NURSING ADMINISTRATION	13.00	0	33.01
33.02	ADMINISTRATIVE & GENERAL	B	-55	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	BAD DEBT	A	30	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04	DIETARY	B	-8,880	DIETARY	10.00	0	33.04
33.05	LOBBYING	A	-493	ADMINISTRATIVE & GENERAL	5.00	0	33.05
33.06	HOSPITAL PROVIDER TAX	A	-1,525,938	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07	IC PHYSICIAN FUND	A	-1,532,569	ADMINISTRATIVE & GENERAL	5.00	0	33.07
33.08	AMBULANCE	A	-51,974	ADMINISTRATIVE & GENERAL	5.00	0	33.08
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-1,838,319				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: 15-1335 | Period: From 07/01/2021 To 06/30/2022 | Worksheet A-8-1 | Date/Time Prepared: 11/28/2022 2:22 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	5.00	ADMINISTRATIVE & GENERAL	Home Office - Capital	328,174	0	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	Home Office - Interest	8,646	0	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	Home Office - Other	5,463,079	4,141,890	3.00
3.01	4.00	EMPLOYEE BENEFITS DEPARTMENT	SVH CHARGEBACKS	2,242	2,242	3.01
3.02	15.00	PHARMACY	SVH CHARGEBACKS	20,000	20,000	3.02
3.03	30.00	ADULTS & PEDIATRICS	SVH CHARGEBACKS	38,500	38,500	3.03
3.04	54.00	RADIOLOGY-DIAGNOSTIC	SVH CHARGEBACKS	2,302	2,302	3.04
3.05	0.00			0	0	3.05
3.06	91.00	EMERGENCY	SVH CHARGEBACKS	7,700	7,700	3.06
3.07	4.00	EMPLOYEE BENEFITS DEPARTMENT	HEALTH INSURANCE	983,383	927,861	3.07
3.08	1.00	CAP REL COSTS-BLDG & FIXT	INTEREST EXPENSE	246,890	249,723	3.08
3.09	5.00	ADMINISTRATIVE & GENERAL	INTEREST EXPENSE	1,276	0	3.09
3.10	71.00	MEDICAL SUPPLIES CHARGED TO	TRG ADMIN FEES - SUPPLIES	-35,988	0	3.10
3.11	13.00	NURSING ADMINISTRATION	TRG ADMIN FEES - CONTRACTED	-2,357	0	3.11
3.12	5.00	ADMINISTRATIVE & GENERAL	TRG ADMIN FEES - OTHER	-37,546	0	3.12
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.			7,026,301	5,390,218	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	G	ASCENSION SVH	100.00	ASCENSION SVH	100.00	6.00
7.00	G	ASCENSION	100.00	ASCENSION	100.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:	HOME OFFICE				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: 15-1335	Period: From 07/01/2021 To 06/30/2022	Worksheet A-8-1 Date/Time Prepared: 11/28/2022 2:22 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	328,174	0		1.00
2.00	8,646	0		2.00
3.00	1,321,189	0		3.00
3.01	0	0		3.01
3.02	0	0		3.02
3.03	0	0		3.03
3.04	0	0		3.04
3.05	0	0		3.05
3.06	0	0		3.06
3.07	55,522	0		3.07
3.08	-2,833	11		3.08
3.09	1,276	0		3.09
3.10	-35,988	0		3.10
3.11	-2,357	0		3.11
3.12	-37,546	0		3.12
4.00	0	0		4.00
5.00	1,636,083			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	ADMINISTRATION		6.00
7.00	ADMINISTRATION		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: 15-1335 | Period: From 07/01/2021 To 06/30/2022 | Worksheet A-8-2 | Date/Time Prepared: 11/28/2022 2:22 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	24,000	24,000	0	0	0	1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	8,150	8,150	0	0	0	2.00
3.00	91.00	EMERGENCY	1,452,570	0	1,452,570	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,484,720	32,150	1,452,570		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	2.00
3.00	91.00	EMERGENCY	0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	24,000		1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	8,150		2.00
3.00	91.00	EMERGENCY	0	0	0	0		3.00
4.00	0.00		0	0	0	0		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	32,150		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 15-1335	Period: From 07/01/2021 To 06/30/2022	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/28/2022 2:22 pm

		Physical Therapy	Cost	
			1.00	
	PART I - GENERAL INFORMATION			
1.00	Total number of weeks worked (excluding aides) (see instructions)		52	1.00
2.00	Line 1 multiplied by 15 hours per week		780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)		230	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)		26	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)		0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)		0	6.00
7.00	Standard travel expense rate		9.57	7.00
8.00	Optional travel expense rate per mile		0.00	8.00

		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	1,889.00	560.00	1,724.00	1,837.00	0.00	9.00
10.00	AHSEA (see instructions)	104.42	90.80	59.02	59.02	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	45.40	45.40	29.51			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01

			1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION			
14.00	Supervisors (column 1, line 9 times column 1, line 10)		197,249	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)		50,848	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)		101,750	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)		349,847	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)		108,420	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)		0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)		458,267	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.			
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)		0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)		0	22.00
23.00	Total salary equivalency (see instructions)		458,267	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE			
	Standard Travel Allowance			
24.00	Therapists (line 3 times column 2, line 11)		10,442	24.00
25.00	Assistants (line 4 times column 3, line 11)		767	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)		11,209	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)		2,450	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)		13,659	28.00
	Optional Travel Allowance and Optional Travel Expense			
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)		0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)		0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)		0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)		0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)		13,659	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)		0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)		0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE			
	Standard Travel Expense			
36.00	Therapists (line 5 times column 2, line 11)		0	36.00
37.00	Assistants (line 6 times column 3, line 11)		0	37.00
38.00	Subtotal (sum of lines 36 and 37)		0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)		0	39.00
	Optional Travel Allowance and Optional Travel Expense			
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)		0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)		0	41.00
42.00	Subtotal (sum of lines 40 and 41)		0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)		0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.			
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)		0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)		0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 15-1335 | Period: From 07/01/2021 To 06/30/2022 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 11/28/2022 2:22 pm

Physical Therapy | Cost

						1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	90.80	59.02	59.02	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00		
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT			
57.00	Salary equivalency amount (from line 23)	458,267		57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	13,659		58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0		59.00
60.00	Overtime allowance (from column 5, line 56)	0		60.00
61.00	Equipment cost (see instructions)	0		61.00
62.00	Supplies (see instructions)	0		62.00
63.00	Total allowance (sum of lines 57-62)	471,926		63.00
64.00	Total cost of outside supplier services (from your records)	352,895		64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0		65.00
	LINE 33 CALCULATION			
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	11,209		100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	2,450		100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	13,659		100.02
	LINE 34 CALCULATION			
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	2,450		101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0		101.01
101.02	Line 34 = sum of lines 27 and 31	2,450		101.02
	LINE 35 CALCULATION			
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0		102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0		102.01
102.02	Line 35 = sum of lines 31 and 32	0		102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 15-1335	Period: From 07/01/2021 To 06/30/2022	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/28/2022 2:22 pm

		Occupational Therapy	Cost	
			1.00	
	PART I - GENERAL INFORMATION			
1.00	Total number of weeks worked (excluding aides) (see instructions)		52	1.00
2.00	Line 1 multiplied by 15 hours per week		780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)		272	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)		0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)		0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)		0	6.00
7.00	Standard travel expense rate		9.57	7.00
8.00	Optional travel expense rate per mile		0.00	8.00

		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	1,669.00	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	86.07	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	43.04	43.04	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01

		1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION		
14.00	Supervisors (column 1, line 9 times column 1, line 10)	0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)	143,651	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)	0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)	143,651	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)	0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)	0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)	143,651	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.		
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)	0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)	0	22.00
23.00	Total salary equivalency (see instructions)	143,651	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE		
	Standard Travel Allowance		
24.00	Therapists (line 3 times column 2, line 11)	11,707	24.00
25.00	Assistants (line 4 times column 3, line 11)	0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)	11,707	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)	2,603	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)	14,310	28.00
	Optional Travel Allowance and Optional Travel Expense		
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)	0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)	0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)	0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)	0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)	14,310	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)	0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)	0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE		
	Standard Travel Expense		
36.00	Therapists (line 5 times column 2, line 11)	0	36.00
37.00	Assistants (line 6 times column 3, line 11)	0	37.00
38.00	Subtotal (sum of lines 36 and 37)	0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)	0	39.00
	Optional Travel Allowance and Optional Travel Expense		
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)	0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)	0	41.00
42.00	Subtotal (sum of lines 40 and 41)	0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)	0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.		
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)	0	44.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 15-1335	Period: From 07/01/2021 To 06/30/2022	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/28/2022 2:22 pm

		Occupational Therapy	Cost	
			1.00	
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)		0	45.00
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)		0	46.00

		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	86.07	0.00	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

			1.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT			
57.00	Salary equivalency amount (from line 23)		143,651	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))		14,310	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)		0	59.00
60.00	Overtime allowance (from column 5, line 56)		0	60.00
61.00	Equipment cost (see instructions)		0	61.00
62.00	Supplies (see instructions)		0	62.00
63.00	Total allowance (sum of lines 57-62)		157,961	63.00
64.00	Total cost of outside supplier services (from your records)		98,000	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)		0	65.00
	LINE 33 CALCULATION			
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others		11,707	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others		2,603	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27		14,310	100.02
	LINE 34 CALCULATION			
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others		2,603	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others		0	101.01
101.02	Line 34 = sum of lines 27 and 31		2,603	101.02
	LINE 35 CALCULATION			
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others		0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others		0	102.01
102.02	Line 35 = sum of lines 31 and 32		0	102.02

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1335 | Period: From 07/01/2021 To 06/30/2022 | Worksheet B Part I Date/Time Prepared: 11/28/2022 2:22 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	455,563	455,563				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	425,629		425,629			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,731,832	1,931	1,804	1,735,567		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	6,244,056	48,234	45,065	93,320	6,430,675	5.00
7.00	00700	OPERATION OF PLANT	1,283,991	59,499	55,583	0	1,399,073	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	105,380	6,278	5,866	0	117,524	8.00
9.00	00900	HOUSEKEEPING	444,136	6,373	5,955	0	456,464	9.00
10.00	01000	DIETARY	110,053	21,037	19,655	0	150,745	10.00
11.00	01100	CAFETERIA	356,413	0	0	0	356,413	11.00
13.00	01300	NURSING ADMINISTRATION	176,706	7,123	6,655	43,205	233,689	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	11,728	14,538	13,583	0	39,849	14.00
15.00	01500	PHARMACY	666,267	8,087	7,555	72,196	754,105	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	440	22,622	21,136	0	44,198	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,623,344	38,911	36,354	405,543	2,104,152	30.00
43.00	04300	NURSERY	366,602	2,310	2,158	86,649	457,719	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	831,639	48,008	44,854	155,098	1,079,599	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	821,439	29,399	27,468	194,152	1,072,458	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	983,006	34,180	31,934	234,706	1,283,826	54.00
60.00	06000	LABORATORY	1,831,919	12,092	11,298	0	1,855,309	60.00
65.00	06500	RESPIRATORY THERAPY	472,107	8,149	7,614	122,640	610,510	65.00
66.00	06600	PHYSICAL THERAPY	356,167	13,281	12,409	0	381,857	66.00
67.00	06700	OCCUPATIONAL THERAPY	98,000	1,392	1,301	0	100,693	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	151,239	7,690	7,185	38,318	204,432	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	84,846	0	0	0	84,846	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	29,820	0	0	0	29,820	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	07501	SLEEP DISORDER	0	0	0	0	0	75.01
76.00	03950	SENIOR RENEWAL CENTER	403,876	9,835	9,189	12	422,912	76.00
76.97	07697	CARDIAC REHABILITATION	65,654	1,502	1,404	17,284	85,844	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	2,614,807	21,927	20,486	272,444	2,929,664	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	22,746,659	424,398	396,511	1,735,567	22,686,376	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1,568	1,465	0	3,033	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	29,597	27,653	0	57,250	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	MARKETING	0	0	0	0	0	194.00
194.01	07951	FOUNDATION	0	0	0	0	0	194.01
194.02	07952	COMMUNITY OUTREACH	0	0	0	0	0	194.02
194.03	07953	WIC	0	0	0	0	0	194.03
194.04	07954	GRANTS	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	22,746,659	455,563	425,629	1,735,567	22,746,659	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1335 | Period: From 07/01/2021 To 06/30/2022 | Worksheet B Part I Date/Time Prepared: 11/28/2022 2:22 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	6,430,675					5.00
7.00	00700	OPERATION OF PLANT	551,421	1,950,494				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	46,320	33,738	197,582			8.00
9.00	00900	HOUSEKEEPING	179,908	34,250	0	670,622		9.00
10.00	01000	DIETARY	59,414	113,049	0	40,273	363,481	10.00
11.00	01100	CAFETERIA	140,474	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	92,105	38,281	0	13,637	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	15,706	78,125	0	27,831	0	14.00
15.00	01500	PHARMACY	297,218	43,457	0	15,481	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	17,420	121,568	0	43,307	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	829,316	209,101	30,190	74,490	363,481	30.00
43.00	04300	NURSERY	180,402	12,414	14,502	4,422	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	425,506	257,990	27,283	91,908	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	422,691	157,989	32,488	56,282	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	505,998	183,680	32,137	65,434	0	54.00
60.00	06000	LABORATORY	731,239	64,983	0	23,149	0	60.00
65.00	06500	RESPIRATORY THERAPY	240,622	43,794	0	15,601	0	65.00
66.00	06600	PHYSICAL THERAPY	150,502	71,372	16,874	25,425	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	39,686	7,481	3,809	2,665	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	80,573	41,327	14,636	14,722	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	33,441	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	11,753	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	07501	SLEEP DISORDER	0	0	0	0	0	75.01
76.00	03950	SENIOR RENEWAL CENTER	166,684	52,852	0	18,828	0	76.00
76.97	07697	CARDIAC REHABILITATION	33,834	8,074	0	2,876	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	1,154,683	117,834	25,663	41,977	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	6,406,916	1,691,359	197,582	578,308	363,481	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,195	8,424	0	3,001	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	22,564	250,711	0	89,313	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	MARKETING	0	0	0	0	0	194.00
194.01	07951	FOUNDATION	0	0	0	0	0	194.01
194.02	07952	COMMUNITY OUTREACH	0	0	0	0	0	194.02
194.03	07953	WIC	0	0	0	0	0	194.03
194.04	07954	GRANTS	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	6,430,675	1,950,494	197,582	670,622	363,481	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1335 | Period: From 07/01/2021 To 06/30/2022 | Worksheet B Part I Date/Time Prepared: 11/28/2022 2:22 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	496,887					11.00
13.00	01300	NURSING ADMINISTRATION	14,513	392,225				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	161,511			14.00
15.00	01500	PHARMACY	18,559	0	1,936	1,130,756		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	226,493	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	110,642	129,997	12,511	0	8,166	30.00
43.00	04300	NURSERY	23,990	28,187	4,635	0	3,302	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	72,746	85,472	78,836	0	41,672	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	53,758	63,162	10,386	0	7,398	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	72,607	0	8,037	0	47,341	54.00
60.00	06000	LABORATORY	0	0	0	0	54,468	60.00
65.00	06500	RESPIRATORY THERAPY	37,544	0	3,784	0	4,079	65.00
66.00	06600	PHYSICAL THERAPY	0	0	634	0	8,720	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	1,970	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	14,130	0	3,328	0	11,145	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	7,817	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	10,695	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,130,756	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	07501	SLEEP DISORDER	0	0	0	0	0	75.01
76.00	03950	SENIOR RENEWAL CENTER	7	0	0	0	3,351	76.00
76.97	07697	CARDIAC REHABILITATION	5,700	0	332	0	589	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	72,691	85,407	18,580	0	34,292	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	496,887	392,225	161,511	1,130,756	226,493	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
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	MARKETING	0	0	0	0	0	194.00
194.01	07951	FOUNDATION	0	0	0	0	0	194.01
194.02	07952	COMMUNITY OUTREACH	0	0	0	0	0	194.02
194.03	07953	WIC	0	0	0	0	0	194.03
194.04	07954	GRANTS	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	496,887	392,225	161,511	1,130,756	226,493	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1335 | Period: From 07/01/2021 To 06/30/2022 | Worksheet B Part I | Date/Time Prepared: 11/28/2022 2:22 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	3,872,046	0	3,872,046		30.00
43.00	04300	NURSERY	729,573	0	729,573		43.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	2,161,012	0	2,161,012		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,876,612	0	1,876,612		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,199,060	0	2,199,060		54.00
60.00	06000	LABORATORY	2,729,148	0	2,729,148		60.00
65.00	06500	RESPIRATORY THERAPY	955,934	0	955,934		65.00
66.00	06600	PHYSICAL THERAPY	655,384	0	655,384		66.00
67.00	06700	OCCUPATIONAL THERAPY	156,304	0	156,304		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	384,293	0	384,293		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	126,104	0	126,104		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	52,268	0	52,268		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,130,756	0	1,130,756		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0		75.00
75.01	07501	SLEEP DISORDER	0	0	0		75.01
76.00	03950	SENIOR RENEWAL CENTER	664,634	0	664,634		76.00
76.97	07697	CARDIAC REHABILITATION	137,249	0	137,249		76.97
		OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	4,480,791	0	4,480,791		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0			92.00
		SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	22,311,168	0	22,311,168		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	15,653	0	15,653		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	419,838	0	419,838		192.00
193.00	19300	NONPAID WORKERS	0	0	0		193.00
194.00	07950	MARKETING	0	0	0		194.00
194.01	07951	FOUNDATION	0	0	0		194.01
194.02	07952	COMMUNITY OUTREACH	0	0	0		194.02
194.03	07953	WIC	0	0	0		194.03
194.04	07954	GRANTS	0	0	0		194.04
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	22,746,659	0	22,746,659		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1335 | Period: From 07/01/2021 To 06/30/2022 | Worksheet B Part II Date/Time Prepared: 11/28/2022 2:22 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	1,931	1,804	3,735	3,735	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	396,313	48,234	45,065	489,612	201	5.00
7.00	00700	OPERATION OF PLANT	0	59,499	55,583	115,082	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	6,278	5,866	12,144	0	8.00
9.00	00900	HOUSEKEEPING	0	6,373	5,955	12,328	0	9.00
10.00	01000	DIETARY	0	21,037	19,655	40,692	0	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	7,123	6,655	13,778	93	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	14,538	13,583	28,121	0	14.00
15.00	01500	PHARMACY	38,550	8,087	7,555	54,192	155	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	22,622	21,136	43,758	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,074	38,911	36,354	76,339	874	30.00
43.00	04300	NURSERY	0	2,310	2,158	4,468	186	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	48,008	44,854	92,862	334	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	29,399	27,468	56,867	418	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	53,660	34,180	31,934	119,774	505	54.00
60.00	06000	LABORATORY	0	12,092	11,298	23,390	0	60.00
65.00	06500	RESPIRATORY THERAPY	6,462	8,149	7,614	22,225	264	65.00
66.00	06600	PHYSICAL THERAPY	0	13,281	12,409	25,690	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,392	1,301	2,693	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	7,690	7,185	14,875	82	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	07501	SLEEP DISORDER	0	0	0	0	0	75.01
76.00	03950	SENIOR RENEWAL CENTER	0	9,835	9,189	19,024	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	1,502	1,404	2,906	37	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	21,927	20,486	42,413	586	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	496,059	424,398	396,511	1,316,968	3,735	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1,568	1,465	3,033	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	29,597	27,653	57,250	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	MARKETING	0	0	0	0	0	194.00
194.01	07951	FOUNDATION	0	0	0	0	0	194.01
194.02	07952	COMMUNITY OUTREACH	0	0	0	0	0	194.02
194.03	07953	WIC	0	0	0	0	0	194.03
194.04	07954	GRANTS	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	496,059	455,563	425,629	1,377,251	3,735	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1335 | Period: From 07/01/2021 To 06/30/2022 | Worksheet B Part II Date/Time Prepared: 11/28/2022 2:22 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	489,813					5.00
7.00	00700	OPERATION OF PLANT	42,000	157,082				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,528	2,717	18,389			8.00
9.00	00900	HOUSEKEEPING	13,703	2,758	0	28,789		9.00
10.00	01000	DIETARY	4,525	9,104	0	1,729	56,050	10.00
11.00	01100	CAFETERIA	10,700	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	7,015	3,083	0	585	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,196	6,292	0	1,195	0	14.00
15.00	01500	PHARMACY	22,638	3,500	0	665	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,327	9,790	0	1,859	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	63,167	16,840	2,810	3,198	56,050	30.00
43.00	04300	NURSERY	13,741	1,000	1,350	190	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	32,410	20,778	2,539	3,946	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	32,195	12,724	3,023	2,416	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	38,540	14,793	2,991	2,809	0	54.00
60.00	06000	LABORATORY	55,696	5,233	0	994	0	60.00
65.00	06500	RESPIRATORY THERAPY	18,328	3,527	0	670	0	65.00
66.00	06600	PHYSICAL THERAPY	11,463	5,748	1,571	1,091	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,023	602	355	114	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	6,137	3,328	1,362	632	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,547	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	895	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	07501	SLEEP DISORDER	0	0	0	0	0	75.01
76.00	03950	SENIOR RENEWAL CENTER	12,696	4,256	0	808	0	76.00
76.97	07697	CARDIAC REHABILITATION	2,577	650	0	123	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	87,956	9,490	2,388	1,802	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	488,003	136,213	18,389	24,826	56,050	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	91	678	0	129	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,719	20,191	0	3,834	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	MARKETING	0	0	0	0	0	194.00
194.01	07951	FOUNDATION	0	0	0	0	0	194.01
194.02	07952	COMMUNITY OUTREACH	0	0	0	0	0	194.02
194.03	07953	WIC	0	0	0	0	0	194.03
194.04	07954	GRANTS	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	489,813	157,082	18,389	28,789	56,050	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1335 | Period: From 07/01/2021 To 06/30/2022 | Worksheet B Part II | Date/Time Prepared: 11/28/2022 2:22 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	10,700					11.00
13.00	01300	NURSING ADMINISTRATION	313	24,867				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	36,804			14.00
15.00	01500	PHARMACY	400	0	441	81,991		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	56,734	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,381	8,242	2,851	0	2,046	30.00
43.00	04300	NURSERY	517	1,787	1,056	0	827	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,567	5,419	17,966	0	10,440	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,158	4,004	2,367	0	1,853	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,564	0	1,831	0	11,860	54.00
60.00	06000	LABORATORY	0	0	0	0	13,637	60.00
65.00	06500	RESPIRATORY THERAPY	808	0	862	0	1,022	65.00
66.00	06600	PHYSICAL THERAPY	0	0	144	0	2,185	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	494	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	304	0	758	0	2,792	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	1,781	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	2,437	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	81,991	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	07501	SLEEP DISORDER	0	0	0	0	0	75.01
76.00	03950	SENIOR RENEWAL CENTER	0	0	0	0	839	76.00
76.97	07697	CARDIAC REHABILITATION	123	0	76	0	148	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	1,565	5,415	4,234	0	8,591	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	10,700	24,867	36,804	81,991	56,734	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
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	MARKETING	0	0	0	0	0	194.00
194.01	07951	FOUNDATION	0	0	0	0	0	194.01
194.02	07952	COMMUNITY OUTREACH	0	0	0	0	0	194.02
194.03	07953	WIC	0	0	0	0	0	194.03
194.04	07954	GRANTS	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	10,700	24,867	36,804	81,991	56,734	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1335 | Period: From 07/01/2021 To 06/30/2022 | Worksheet B Part II Date/Time Prepared: 11/28/2022 2:22 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	234,798	0	234,798		30.00
43.00	04300	NURSERY	25,122	0	25,122		43.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	188,261	0	188,261		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	117,025	0	117,025		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	194,667	0	194,667		54.00
60.00	06000	LABORATORY	98,950	0	98,950		60.00
65.00	06500	RESPIRATORY THERAPY	47,706	0	47,706		65.00
66.00	06600	PHYSICAL THERAPY	47,892	0	47,892		66.00
67.00	06700	OCCUPATIONAL THERAPY	7,281	0	7,281		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	30,270	0	30,270		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,328	0	4,328		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,332	0	3,332		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	81,991	0	81,991		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0		75.00
75.01	07501	SLEEP DISORDER	0	0	0		75.01
76.00	03950	SENIOR RENEWAL CENTER	37,623	0	37,623		76.00
76.97	07697	CARDIAC REHABILITATION	6,640	0	6,640		76.97
		OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	164,440	0	164,440		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0			92.00
		SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,290,326	0	1,290,326		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	3,931	0	3,931		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	82,994	0	82,994		192.00
193.00	19300	NONPAID WORKERS	0	0	0		193.00
194.00	07950	MARKETING	0	0	0		194.00
194.01	07951	FOUNDATION	0	0	0		194.01
194.02	07952	COMMUNITY OUTREACH	0	0	0		194.02
194.03	07953	WIC	0	0	0		194.03
194.04	07954	GRANTS	0	0	0		194.04
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	1,377,251	0	1,377,251		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1335 | Period: From 07/01/2021 To 06/30/2022 | Worksheet B-1 | Date/Time Prepared: 11/28/2022 2:22 pm

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	181,625					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		181,625				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	770	770	6,415,798			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	19,230	19,230	344,970	-6,430,675	16,315,984	5.00
7.00	00700	OPERATION OF PLANT	23,720	23,720	0	0	1,399,073	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,503	2,503	0	0	117,524	8.00
9.00	00900	HOUSEKEEPING	2,541	2,541	0	0	456,464	9.00
10.00	01000	DIETARY	8,387	8,387	0	0	150,745	10.00
11.00	01100	CAFETERIA	0	0	0	0	356,413	11.00
13.00	01300	NURSING ADMINISTRATION	2,840	2,840	159,714	0	233,689	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	5,796	5,796	0	0	39,849	14.00
15.00	01500	PHARMACY	3,224	3,224	266,883	0	754,105	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	9,019	9,019	0	0	44,198	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	15,513	15,513	1,499,166	0	2,104,152	30.00
43.00	04300	NURSERY	921	921	320,310	0	457,719	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	19,140	19,140	573,345	0	1,079,599	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	11,721	11,721	717,713	0	1,072,458	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	13,627	13,627	867,627	0	1,283,826	54.00
60.00	06000	LABORATORY	4,821	4,821	0	0	1,855,309	60.00
65.00	06500	RESPIRATORY THERAPY	3,249	3,249	453,356	0	610,510	65.00
66.00	06600	PHYSICAL THERAPY	5,295	5,295	0	0	381,857	66.00
67.00	06700	OCCUPATIONAL THERAPY	555	555	0	0	100,693	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	3,066	3,066	141,649	0	204,432	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	84,846	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	29,820	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	07501	SLEEP DISORDER	0	0	0	0	0	75.01
76.00	03950	SENIOR RENEWAL CENTER	3,921	3,921	43	0	422,912	76.00
76.97	07697	CARDIAC REHABILITATION	599	599	63,893	0	85,844	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	8,742	8,742	1,007,129	0	2,929,664	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	169,200	169,200	6,415,798	-6,430,675	16,255,701	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	625	625	0	0	3,033	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	11,800	11,800	0	0	57,250	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	MARKETING	0	0	0	0	0	194.00
194.01	07951	FOUNDATION	0	0	0	0	0	194.01
194.02	07952	COMMUNITY OUTREACH	0	0	0	0	0	194.02
194.03	07953	WIC	0	0	0	0	0	194.03
194.04	07954	GRANTS	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	455,563	425,629	1,735,567		6,430,675	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	2.508262	2.343449	0.270515		0.394133	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			3,735		489,813	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000582		0.030020	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: 15-1335 | Period: From 07/01/2021 To 06/30/2022 | Worksheet B-1 | Date/Time Prepared: 11/28/2022 2:22 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (TOTAL PATIENT DAYS)	CAFETERIA (PAID HOURS)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	144,705					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,503	23,652				8.00
9.00	00900	HOUSEKEEPING	2,541	0	139,661			9.00
10.00	01000	DIETARY	8,387	0	8,387	1,187		10.00
11.00	01100	CAFETERIA	0	0	0	0	135,208	11.00
13.00	01300	NURSING ADMINISTRATION	2,840	0	2,840	0	3,949	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	5,796	0	5,796	0	0	14.00
15.00	01500	PHARMACY	3,224	0	3,224	0	5,050	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	9,019	0	9,019	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	15,513	3,614	15,513	1,187	30,107	30.00
43.00	04300	NURSERY	921	1,736	921	0	6,528	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	19,140	3,266	19,140	0	19,795	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	11,721	3,889	11,721	0	14,628	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	13,627	3,847	13,627	0	19,757	54.00
60.00	06000	LABORATORY	4,821	0	4,821	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	3,249	0	3,249	0	10,216	65.00
66.00	06600	PHYSICAL THERAPY	5,295	2,020	5,295	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	555	456	555	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	3,066	1,752	3,066	0	3,845	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	07501	SLEEP DISORDER	0	0	0	0	0	75.01
76.00	03950	SENIOR RENEWAL CENTER	3,921	0	3,921	0	2	76.00
76.97	07697	CARDIAC REHABILITATION	599	0	599	0	1,551	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	8,742	3,072	8,742	0	19,780	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	125,480	23,652	120,436	1,187	135,208	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	625	0	625	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	18,600	0	18,600	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	MARKETING	0	0	0	0	0	194.00
194.01	07951	FOUNDATION	0	0	0	0	0	194.01
194.02	07952	COMMUNITY OUTREACH	0	0	0	0	0	194.02
194.03	07953	WIC	0	0	0	0	0	194.03
194.04	07954	GRANTS	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,950,494	197,582	670,622	363,481	496,887	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	13.479106	8.353712	4.801784	306.218197	3.674982	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	157,082	18,389	28,789	56,050	10,700	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1.085533	0.777482	0.206135	47.219882	0.079137	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: 15-1335 | Period: From 07/01/2021 To 06/30/2022 | Worksheet B-1 | Date/Time Prepared: 11/28/2022 2:22 pm

		Cost Center Description	NURSING ADMINISTRATION (PAID HOURS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)		
			13.00	14.00	15.00	16.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	90,838					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	450,310				14.00
15.00	01500	PHARMACY	0	5,397	100			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	52,443,149		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	30,107	34,882	0	1,890,635		30.00
43.00	04300	NURSERY	6,528	12,923	0	764,495		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	19,795	219,802	0	9,648,416		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	14,628	28,957	0	1,712,993		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	22,407	0	10,961,059		54.00
60.00	06000	LABORATORY	0	0	0	12,613,400		60.00
65.00	06500	RESPIRATORY THERAPY	0	10,551	0	944,430		65.00
66.00	06600	PHYSICAL THERAPY	0	1,768	0	2,019,014		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	456,228		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	9,279	0	2,580,462		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	21,795	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	29,820	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	100	0		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0		75.00
75.01	07501	SLEEP DISORDER	0	0	0	0		75.01
76.00	03950	SENIOR RENEWAL CENTER	0	0	0	775,776		76.00
76.97	07697	CARDIAC REHABILITATION	0	927	0	136,436		76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	19,780	51,802	0	7,939,805		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	90,838	450,310	100	52,443,149		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
193.00	19300	NONPAID WORKERS	0	0	0	0		193.00
194.00	07950	MARKETING	0	0	0	0		194.00
194.01	07951	FOUNDATION	0	0	0	0		194.01
194.02	07952	COMMUNITY OUTREACH	0	0	0	0		194.02
194.03	07953	WIC	0	0	0	0		194.03
194.04	07954	GRANTS	0	0	0	0		194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	392,225	161,511	1,130,756	226,493		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	4.317852	0.358666	11,307.560000	0.004319		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	24,867	36,804	81,991	56,734		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.273751	0.081730	819.910000	0.001082		205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1335 | Period: From 07/01/2021 To 06/30/2022 | Worksheet C Part I Date/Time Prepared: 11/28/2022 2:22 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,872,046		3,872,046	0	0	30.00
43.00	04300	NURSERY	729,573		729,573	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,161,012		2,161,012	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,876,612		1,876,612	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,199,060		2,199,060	0	0	54.00
60.00	06000	LABORATORY	2,729,148		2,729,148	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	955,934	0	955,934	0	0	65.00
66.00	06600	PHYSICAL THERAPY	655,384	0	655,384	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	156,304	0	156,304	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	384,293		384,293	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	126,104		126,104	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	52,268		52,268	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,130,756		1,130,756	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0		0	0	0	75.00
75.01	07501	SLEEP DISORDER	0		0	0	0	75.01
76.00	03950	SENIOR RENEWAL CENTER	664,634		664,634	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	137,249		137,249	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	4,480,791		4,480,791	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	673,305		673,305		0	92.00
200.00		Subtotal (see instructions)	22,984,473	0	22,984,473	0	0	200.00
201.00		Less Observation Beds	673,305		673,305		0	201.00
202.00		Total (see instructions)	22,311,168	0	22,311,168	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1335 | Period: From 07/01/2021 To 06/30/2022 | Worksheet C Part I Date/Time Prepared: 11/28/2022 2:22 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,592,272		1,592,272			30.00
43.00	04300	NURSERY	764,495		764,495			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,181,888	7,466,528	9,648,416	0.223976	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,491,094	221,899	1,712,993	1.095516	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	450,948	10,510,111	10,961,059	0.200625	0.000000	54.00
60.00	06000	LABORATORY	977,691	11,635,709	12,613,400	0.216369	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	493,422	451,008	944,430	1.012181	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	85,641	1,933,373	2,019,014	0.324606	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	41,895	414,333	456,228	0.342601	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	168,978	2,411,484	2,580,462	0.148924	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	451,279	686,996	1,138,275	0.110785	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	10,492	97,364	107,856	0.484609	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,188,732	1,993,523	3,182,255	0.355332	0.000000	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0.000000	0.000000	75.00
75.01	07501	SLEEP DISORDER	0	0	0	0.000000	0.000000	75.01
76.00	03950	SENIOR RENEWAL CENTER	0	775,776	775,776	0.856734	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	136,436	136,436	1.005959	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	162,402	7,777,403	7,939,805	0.564345	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	33,294	265,069	298,363	2.256664	0.000000	92.00
200.00		Subtotal (see instructions)	10,094,523	46,777,012	56,871,535			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	10,094,523	46,777,012	56,871,535			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1335 | Period: From 07/01/2021 To 06/30/2022 | Worksheet C Part I Date/Time Prepared: 11/28/2022 2:22 pm

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
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 PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000		75.00
75.01	07501	SLEEP DISORDER	0.000000		75.01
76.00	03950	SENIOR RENEWAL CENTER	0.000000		76.00
76.97	07697	CARDIAC REHABILITATION	0.000000		76.97
		OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
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: 15-1335 | Period: From 07/01/2021 To 06/30/2022 | Worksheet C Part I Date/Time Prepared: 11/28/2022 2:22 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	3,872,046		3,872,046	0	3,872,046	30.00
43.00	04300	NURSERY	729,573		729,573	0	729,573	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,161,012		2,161,012	0	2,161,012	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,876,612		1,876,612	0	1,876,612	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,199,060		2,199,060	0	2,199,060	54.00
60.00	06000	LABORATORY	2,729,148		2,729,148	0	2,729,148	60.00
65.00	06500	RESPIRATORY THERAPY	955,934	0	955,934	0	955,934	65.00
66.00	06600	PHYSICAL THERAPY	655,384	0	655,384	0	655,384	66.00
67.00	06700	OCCUPATIONAL THERAPY	156,304	0	156,304	0	156,304	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	384,293		384,293	0	384,293	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	126,104		126,104	0	126,104	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	52,268		52,268	0	52,268	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,130,756		1,130,756	0	1,130,756	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0		0	0	0	75.00
75.01	07501	SLEEP DISORDER	0		0	0	0	75.01
76.00	03950	SENIOR RENEWAL CENTER	664,634		664,634	0	664,634	76.00
76.97	07697	CARDIAC REHABILITATION	137,249		137,249	0	137,249	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	4,480,791		4,480,791	0	4,480,791	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	673,305		673,305		673,305	92.00
200.00		Subtotal (see instructions)	22,984,473	0	22,984,473	0	22,984,473	200.00
201.00		Less Observation Beds	673,305		673,305		673,305	201.00
202.00		Total (see instructions)	22,311,168	0	22,311,168	0	22,311,168	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1335 | Period: From 07/01/2021 To 06/30/2022 | Worksheet C Part I Date/Time Prepared: 11/28/2022 2:22 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	1,592,272		1,592,272			30.00
43.00	04300	NURSERY	764,495		764,495			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,181,888	7,466,528	9,648,416	0.223976	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,491,094	221,899	1,712,993	1.095516	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	450,948	10,510,111	10,961,059	0.200625	0.000000	54.00
60.00	06000	LABORATORY	977,691	11,635,709	12,613,400	0.216369	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	493,422	451,008	944,430	1.012181	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	85,641	1,933,373	2,019,014	0.324606	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	41,895	414,333	456,228	0.342601	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	168,978	2,411,484	2,580,462	0.148924	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	451,279	686,996	1,138,275	0.110785	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	10,492	97,364	107,856	0.484609	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,188,732	1,993,523	3,182,255	0.355332	0.000000	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0.000000	0.000000	75.00
75.01	07501	SLEEP DISORDER	0	0	0	0.000000	0.000000	75.01
76.00	03950	SENIOR RENEWAL CENTER	0	775,776	775,776	0.856734	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	136,436	136,436	1.005959	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	162,402	7,777,403	7,939,805	0.564345	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	33,294	265,069	298,363	2.256664	0.000000	92.00
200.00		Subtotal (see instructions)	10,094,523	46,777,012	56,871,535			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	10,094,523	46,777,012	56,871,535			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1335 | Period: From 07/01/2021 To 06/30/2022 | Worksheet C Part I Date/Time Prepared: 11/28/2022 2:22 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
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
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 PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000		75.00
75.01	07501	SLEEP DISORDER	0.000000		75.01
76.00	03950	SENIOR RENEWAL CENTER	0.000000		76.00
76.97	07697	CARDIAC REHABILITATION	0.000000		76.97
		OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-1335 | Period: From 07/01/2021 To 06/30/2022 | Worksheet D Part II Date/Time Prepared: 11/28/2022 2:22 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	188,261	9,648,416	0.019512	178,013	3,473	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	117,025	1,712,993	0.068316	3,836	262	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	194,667	10,961,059	0.017760	102,428	1,819	54.00
60.00	06000	LABORATORY	98,950	12,613,400	0.007845	216,835	1,701	60.00
65.00	06500	RESPIRATORY THERAPY	47,706	944,430	0.050513	95,351	4,816	65.00
66.00	06600	PHYSICAL THERAPY	47,892	2,019,014	0.023720	29,442	698	66.00
67.00	06700	OCCUPATIONAL THERAPY	7,281	456,228	0.015959	8,904	142	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	30,270	2,580,462	0.011730	163,038	1,912	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,328	1,138,275	0.003802	139,773	531	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,332	107,856	0.030893	9,164	283	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	81,991	3,182,255	0.025765	268,912	6,929	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0.000000	0	0	75.00
75.01	07501	SLEEP DISORDER	0	0	0.000000	0	0	75.01
76.00	03950	SENIOR RENEWAL CENTER	37,623	775,776	0.048497	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	6,640	136,436	0.048668	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	164,440	7,939,805	0.020711	1,790	37	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	40,829	298,363	0.136843	2,792	382	92.00
200.00		Total (lines 50 through 199)	1,071,235	54,514,768		1,220,278	22,985	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1335 | Period: From 07/01/2021 To 06/30/2022 | Worksheet D Part IV Date/Time Prepared: 11/28/2022 2:22 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	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
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	07501	SLEEP DISORDER	0	0	0	0	0	75.01
76.00	03950	SENIOR RENEWAL CENTER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1335 | Period: From 07/01/2021 To 06/30/2022 | Worksheet D Part IV Date/Time Prepared: 11/28/2022 2:22 pm

Title XVIII | Hospital | Cost

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	9,648,416	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	1,712,993	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	10,961,059	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	12,613,400	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	944,430	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,019,014	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	456,228	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	2,580,462	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	1,138,275	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	107,856	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	3,182,255	0.000000	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0.000000	75.00
75.01	07501	SLEEP DISORDER	0	0	0	0	0.000000	75.01
76.00	03950	SENIOR RENEWAL CENTER	0	0	0	775,776	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	136,436	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	7,939,805	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	298,363	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	54,514,768		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1335 | Period: From 07/01/2021 To 06/30/2022 | Worksheet D Part IV Date/Time Prepared: 11/28/2022 2:22 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	178,013	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	3,836	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	102,428	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	216,835	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	95,351	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	29,442	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	8,904	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	163,038	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	139,773	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	9,164	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	268,912	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	0	0	75.00
75.01	07501	SLEEP DISORDER	0.000000	0	0	0	0	75.01
76.00	03950	SENIOR RENEWAL CENTER	0.000000	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.000000	1,790	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	2,792	0	0	0	92.00
200.00		Total (lines 50 through 199)		1,220,278	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1335 | Period: From 07/01/2021 To 06/30/2022 | Worksheet D Part V Date/Time Prepared: 11/28/2022 2:22 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.223976	0	1,393,205	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.095516	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.200625	0	2,277,467	0	0	54.00
60.00	06000	LABORATORY	0.216369	0	1,876,101	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	1.012181	0	38,723	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.324606	0	709,570	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.342601	0	117,720	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.148924	0	567,021	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.110785	0	132,588	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.484609	0	23,627	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.355332	0	384,190	1,873	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	0	0	75.00
75.01	07501	SLEEP DISORDER	0.000000	0	0	0	0	75.01
76.00	03950	SENIOR RENEWAL CENTER	0.856734	0	463,596	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	1.005959	0	56,041	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.564345	0	1,373,483	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2.256664	0	111,818	0	0	92.00
200.00		Subtotal (see instructions)		0	9,525,150	1,873	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	9,525,150	1,873	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1335 | Period: From 07/01/2021 To 06/30/2022 | Worksheet D Part V Date/Time Prepared: 11/28/2022 2:22 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	312,044	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	456,917	0		54.00
60.00	06000	LABORATORY	405,930	0		60.00
65.00	06500	RESPIRATORY THERAPY	39,195	0		65.00
66.00	06600	PHYSICAL THERAPY	230,331	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	40,331	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	84,443	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	14,689	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	11,450	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	136,515	666		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0		75.00
75.01	07501	SLEEP DISORDER	0	0		75.01
76.00	03950	SENIOR RENEWAL CENTER	397,178	0		76.00
76.97	07697	CARDIAC REHABILITATION	56,375	0		76.97
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	775,118	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	252,336	0		92.00
200.00		Subtotal (see instructions)	3,212,852	666		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	3,212,852	666		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-1335 | Component CCN: 15-Z335 | Period: From 07/01/2021 To 06/30/2022 | Worksheet D Part V Date/Time Prepared: 11/28/2022 2:22 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.223976	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.095516	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.200625	0	0	0	0	54.00
60.00	06000	LABORATORY	0.216369	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	1.012181	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.324606	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.342601	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.148924	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.110785	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.484609	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.355332	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	0	0	75.00
75.01	07501	SLEEP DISORDER	0.000000	0	0	0	0	75.01
76.00	03950	SENIOR RENEWAL CENTER	0.856734	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	1.005959	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.564345	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2.256664	0	0	0	0	92.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1335 | Component CCN: 15-Z335 | Period: From 07/01/2021 To 06/30/2022 | Worksheet D Part V Date/Time Prepared: 11/28/2022 2:22 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
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 PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0		75.00
75.01	07501	SLEEP DISORDER	0	0		75.01
76.00	03950	SENIOR RENEWAL CENTER	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	0		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1335 | Period: From 07/01/2021 To 06/30/2022 | Worksheet D Part III Date/Time Prepared: 11/28/2022 2:22 pm

Title XIX | Hospital | Cost

		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
43.00	04300	NURSERY	0	0	0	0	0	43.00
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	1,454	0.00	34	30.00
43.00	04300	NURSERY		0	463	0.00	33	43.00
200.00		Total (lines 30 through 199)		0	1,917		67	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
43.00	04300	NURSERY	0	43.00
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1335 | Period: From 07/01/2021 To 06/30/2022 | Worksheet D Part IV Date/Time Prepared: 11/28/2022 2:22 pm

Title XIX | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	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
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	07501	SLEEP DISORDER	0	0	0	0	0	75.01
76.00	03950	SENIOR RENEWAL CENTER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1335 | Period: From 07/01/2021 To 06/30/2022 | Worksheet D Part IV Date/Time Prepared: 11/28/2022 2:22 pm

Title XIX | Hospital | Cost

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	9,648,416	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	1,712,993	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	10,961,059	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	12,613,400	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	944,430	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,019,014	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	456,228	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	2,580,462	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	1,138,275	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	107,856	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	3,182,255	0.000000	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0.000000	75.00
75.01	07501	SLEEP DISORDER	0	0	0	0	0.000000	75.01
76.00	03950	SENIOR RENEWAL CENTER	0	0	0	775,776	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	136,436	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	7,939,805	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	298,363	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	54,514,768		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1335 | Period: From 07/01/2021 To 06/30/2022 | Worksheet D Part IV Date/Time Prepared: 11/28/2022 2:22 pm

Title XIX | Hospital | Cost

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	125,363	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	58,401	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	27,324	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	60,091	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	10,344	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	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	0.000000	1,482	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	10,020	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	44,754	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	0	0	75.00
75.01	07501	SLEEP DISORDER	0.000000	0	0	0	0	75.01
76.00	03950	SENIOR RENEWAL CENTER	0.000000	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.000000	25,232	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	6,796	0	0	0	92.00
200.00		Total (lines 50 through 199)		369,807	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1335 | Period: From 07/01/2021 To 06/30/2022 | Worksheet D-1 | Date/Time Prepared: 11/28/2022 2:22 pm

Title XVIII | Hospital

	Cost Center Description	Cost	
		1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	1,550	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,454	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,187	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	23	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)	57	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	8	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)	8	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	367	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)	23	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)	55	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	231.10	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	231.10	20.00
21.00	Total general inpatient routine service cost (see instructions)	3,872,046	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)	1,849	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)	1,849	25.00
26.00	Total swing-bed cost (see instructions)	205,437	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,666,609	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)	3,666,609	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)	2,521.74	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	925,479	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)	925,479	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1335 | Period: From 07/01/2021 To 06/30/2022 | Worksheet D-1 | Date/Time Prepared: 11/28/2022 2:22 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						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)	367,729	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	1,293,208	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
56.00	Target amount (line 54 x line 55)	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	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 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)	58,000	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	138,696	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	196,696	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)	267	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,521.74	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	673,305	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1335 | Period: From 07/01/2021 To 06/30/2022 | Worksheet D-1 | Date/Time Prepared: 11/28/2022 2:22 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	234,798	3,872,046	0.060639	673,305	40,829	90.00
91.00	Nursing Program cost	0	3,872,046	0.000000	673,305	0	91.00
92.00	Allied health cost	0	3,872,046	0.000000	673,305	0	92.00
93.00	All other Medical Education	0	3,872,046	0.000000	673,305	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1335 | Period: From 07/01/2021 To 06/30/2022 | Worksheet D-1 | Date/Time Prepared: 11/28/2022 2:22 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)	1,550	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,454	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,187	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	40	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)	40	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	8	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)	8	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	34	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)	463	15.00
16.00	Nursery days (title V or XIX only)	33	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	231.10	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	231.10	20.00
21.00	Total general inpatient routine service cost (see instructions)	3,872,046	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)	1,849	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)	1,849	25.00
26.00	Total swing-bed cost (see instructions)	205,437	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,666,609	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)	3,666,609	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)	2,521.74	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	85,739	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)	85,739	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1335 | Period: From 07/01/2021 To 06/30/2022 | Worksheet D-1 | Date/Time Prepared: 11/28/2022 2:22 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)	729,573	463	1,575.75	33	52,000	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	167,821	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	305,560	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
56.00	Target amount (line 54 x line 55)	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	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 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)	267	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,521.74	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	673,305	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1335 | Period: From 07/01/2021 To 06/30/2022 | Worksheet D-1 | Date/Time Prepared: 11/28/2022 2:22 pm

Title XIX | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	234,798	3,872,046	0.060639	673,305	40,829	90.00
91.00	Nursing Program cost	0	3,872,046	0.000000	673,305	0	91.00
92.00	Allied health cost	0	3,872,046	0.000000	673,305	0	92.00
93.00	All other Medical Education	0	3,872,046	0.000000	673,305	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1335 | Period: From 07/01/2021 To 06/30/2022 | Worksheet D-3 | Date/Time Prepared: 11/28/2022 2:22 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		411,593		30.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.223976	178,013	39,871	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.095516	3,836	4,202	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.200625	102,428	20,550	54.00
60.00	06000	LABORATORY	0.216369	216,835	46,916	60.00
65.00	06500	RESPIRATORY THERAPY	1.012181	95,351	96,512	65.00
66.00	06600	PHYSICAL THERAPY	0.324606	29,442	9,557	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.342601	8,904	3,051	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.148924	163,038	24,280	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.110785	139,773	15,485	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.484609	9,164	4,441	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.355332	268,912	95,553	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	75.00
75.01	07501	SLEEP DISORDER	0.000000	0	0	75.01
76.00	03950	SENIOR RENEWAL CENTER	0.856734	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	1.005959	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.564345	1,790	1,010	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2.256664	2,792	6,301	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,220,278	367,729	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)		1,220,278		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1335 | Component CCN: 15-Z335 | Period: From 07/01/2021 To 06/30/2022 | Worksheet D-3 | Date/Time Prepared: 11/28/2022 2:22 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS				30.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.223976	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.095516	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.200625	6,577	1,320	54.00
60.00	06000	LABORATORY	0.216369	15,719	3,401	60.00
65.00	06500	RESPIRATORY THERAPY	1.012181	14,691	14,870	65.00
66.00	06600	PHYSICAL THERAPY	0.324606	22,532	7,314	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.342601	19,174	6,569	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.148924	4,458	664	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.110785	9,800	1,086	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.484609	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.355332	17,731	6,300	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	75.00
75.01	07501	SLEEP DISORDER	0.000000	0	0	75.01
76.00	03950	SENIOR RENEWAL CENTER	0.856734	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	1.005959	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.564345	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2.256664	233	526	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		110,915	42,050	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)		110,915		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1335 | Period: From 07/01/2021 To 06/30/2022 | Worksheet D-3 | Date/Time Prepared: 11/28/2022 2:22 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		19,777		30.00
43.00	04300	NURSERY		26,064		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.223976	125,363	28,078	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.095516	58,401	63,979	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.200625	27,324	5,482	54.00
60.00	06000	LABORATORY	0.216369	60,091	13,002	60.00
65.00	06500	RESPIRATORY THERAPY	1.012181	10,344	10,470	65.00
66.00	06600	PHYSICAL THERAPY	0.324606	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.342601	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.148924	1,482	221	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.110785	10,020	1,110	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.484609	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.355332	44,754	15,903	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	75.00
75.01	07501	SLEEP DISORDER	0.000000	0	0	75.01
76.00	03950	SENIOR RENEWAL CENTER	0.856734	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	1.005959	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.564345	25,232	14,240	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2.256664	6,796	15,336	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		369,807	167,821	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)		369,807		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-1335 | Period: From 07/01/2021 To 06/30/2022 | Worksheet E Part B Date/Time Prepared: 11/28/2022 2:22 pm

Title XVIII | Hospital | Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	3,213,518	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	OPPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	3,213,518	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	3,245,653	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	28,808	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	1,442,319	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)	1,774,526	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)	1,774,526	30.00
31.00	Primary payer payments	3,235	31.00
32.00	Subtotal (line 30 minus line 31)	1,771,291	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)	215,869	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	140,315	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	160,598	36.00
37.00	Subtotal (see instructions)	1,911,606	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
39.97	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)	1,911,606	40.00
40.01	Sequestration adjustment (see instructions)	4,779	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		40.03
41.00	Interim payments	2,140,315	41.00
41.01	Interim payments-PARHM		41.01
42.00	Tentative settlement (for contractors use only)	0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)		42.01
43.00	Balance due provider/program (see instructions)	-233,488	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	25,000	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: 15-1335	Period: From 07/01/2021 To 06/30/2022	Worksheet E Part B Date/Time Prepared: 11/28/2022 2:22 pm
	Title XVIII	Hospital	Cost

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Provider CCN: 15-1335 | Period: From 07/01/2021 To 06/30/2022 | Worksheet E-1 Part I Date/Time Prepared: 11/28/2022 2:22 pm

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		986,055		2,140,315	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)		986,055		2,140,315	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		213,213		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		233,488	6.02
7.00	Total Medicare program liability (see instructions)		1,199,268		1,906,827	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: 15-1335 | Component CCN: 15-Z335 | Period: From 07/01/2021 To 06/30/2022 | Worksheet E-1 Part I | Date/Time Prepared: 11/28/2022 2:22 pm

Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		207,387		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		207,387		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		33,144		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		240,531		0	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-1335	Period: From 07/01/2021 To 06/30/2022	Worksheet E-1 Part II Date/Time Prepared: 11/28/2022 2:22 pm
	Title XVIII	Hospital	Cost

		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14		1.00
2.00	Medicare days (Wkst. S-3, Pt. I, col. 6, sum of lines 1, and 8 through 12, and plus for cost reporting periods beginning on or after 10/01/2013, line 32)		2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2		3.00
4.00	Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of lines 1, and 8 through 12, and plus for cost reporting periods beginning on or after 10/01/2013, line 32)		4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200		5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20		6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168		7.00
8.00	Calculation of the HIT incentive payment (see instructions)		8.00
9.00	Sequestration adjustment amount (see instructions)		9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)		10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)		30.00
31.00	Other Adjustment (specify)		31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)		32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS | Provider CCN: 15-1335 | Component CCN: 15-Z335 | Period: From 07/01/2021 To 06/30/2022 | Worksheet E-2 | Date/Time Prepared: 11/28/2022 2:22 pm

Title XVIII | Swing Beds - SNF | Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	198,663	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swing-bed pass-through, see instructions)	42,471	0	3.00
3.01	Nursing and allied health payment-PARHM (see instructions)			3.01
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	78	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	241,134	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	241,134	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	241,134	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	0	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (see instructions)	241,134	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			16.50
16.55	Rural community hospital demonstration project (§410A Demonstration) payment adjustment (see instructions)	0		16.55
16.99	Demonstration payment adjustment amount before sequestration	0	0	16.99
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	241,134	0	19.00
19.01	Sequestration adjustment (see instructions)	603	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0	0	19.02
19.03	Sequestration adjustment-PARHM pass-throughs			19.03
19.25	Sequestration for non-claims based amounts (see instructions)	0	0	19.25
20.00	Interim payments	207,387	0	20.00
20.01	Interim payments-PARHM			20.01
21.00	Tentative settlement (for contractor use only)	0	0	21.00
21.01	Tentative settlement-PARHM (for contractor use only)			21.01
22.00	Balance due provider/program (line 19 minus lines 19.01, 19.02, 19.25, 20, and 21)	33,144	0	22.00
22.01	Balance due provider/program-PARHM (see instructions)			22.01
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	23.00
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
	Cost Reimbursement			
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))			201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))			202.00
203.00	Total (sum of lines 201 and 202)			203.00
204.00	Medicare swing-bed SNF discharges (see instructions)			204.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
205.00	Medicare swing-bed SNF target amount			205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)			206.00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)			208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
	Comparision of PPS versus Cost Reimbursement			
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)			215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1335	Period: From 07/01/2021 To 06/30/2022	Worksheet E-3 Part V Date/Time Prepared: 11/28/2022 2:22 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	1,293,208	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)	0	2.00
3.00	Organ acquisition	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	1,293,208	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	1,306,140	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	1,306,140	19.00
20.00	Deductibles (exclude professional component)	120,009	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	1,186,131	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	1,186,131	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	24,836	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	16,143	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	15,076	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	1,202,274	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29.98	Recovery of accelerated depreciation.	0	29.98
29.99	Demonstration payment adjustment amount before sequestration	0	29.99
30.00	Subtotal (see instructions)	1,202,274	30.00
30.01	Sequestration adjustment (see instructions)	3,006	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
30.03	Sequestration adjustment-PARHM		30.03
31.00	Interim payments	986,055	31.00
31.01	Interim payments-PARHM		31.01
32.00	Tentative settlement (for contractor use only)	0	32.00
32.01	Tentative settlement-PARHM (for contractor use only)		32.01
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)	213,213	33.00
33.01	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01)		33.01
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	25,000	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1335	Period: From 07/01/2021 To 06/30/2022	Worksheet E-3 Part VII Date/Time Prepared: 11/28/2022 2:22 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	305,560		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	305,560	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)	305,560	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	19,777		8.00
9.00	Ancillary service charges	369,807	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)	389,584	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)	389,584	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	84,024	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)	305,560	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)	305,560	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)	305,560	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)	305,560	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	305,560	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)	305,560	0	40.00
41.00	Interim payments	305,560	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 15-1335 | Period: From 07/01/2021 To 06/30/2022 | Worksheet G | Date/Time Prepared: 11/28/2022 2:22 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	26,774	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	4,517,662	0	0	0	4.00
5.00	Other receivable	1,806,357	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-2,570,387	0	0	0	6.00
7.00	Inventory	382,339	0	0	0	7.00
8.00	Prepaid expenses	0	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)	4,162,745	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	100,000	0	0	0	12.00
13.00	Land improvements	260,287	0	0	0	13.00
14.00	Accumulated depreciation	-95,940	0	0	0	14.00
15.00	Buildings	7,268,893	0	0	0	15.00
16.00	Accumulated depreciation	-3,735,438	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	2,868,890	0	0	0	19.00
20.00	Accumulated depreciation	-1,891,432	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	5,456,380	0	0	0	23.00
24.00	Accumulated depreciation	-4,354,502	0	0	0	24.00
25.00	Minor equipment depreciable	14,216	0	0	0	25.00
26.00	Accumulated depreciation	-1,975	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)	5,889,379	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	10,842	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	10,842	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	10,062,966	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1,556,700	0	0	0	37.00
38.00	Salaries, wages, and fees payable	516,038	0	0	0	38.00
39.00	Payroll taxes payable	92,191	0	0	0	39.00
40.00	Notes and loans payable (short term)	108,722	0	0	0	40.00
41.00	Deferred income	360,638	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	4,110,481	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	6,744,770	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	6,721,891	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	6,721,891	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	13,466,661	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	-3,403,695				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)	-3,403,695	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	10,062,966	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-1335 | Period: From 07/01/2021 To 06/30/2022 | Worksheet G-1 | Date/Time Prepared: 11/28/2022 2:22 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		546,537		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		1,403,935				2.00
3.00	Total (sum of line 1 and line 2)		1,950,472		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	Rounding	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)		1,950,472		0		11.00
12.00	Transfer from Affiliates	5,354,167		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)		5,354,167		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		-3,403,695		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	Rounding		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	Transfer from Affiliates		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: 15-1335 | Period: From 07/01/2021 To 06/30/2022 | Worksheet G-2 Parts I & II Date/Time Prepared: 11/28/2022 2:22 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	4,294,580		4,294,580	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	4,294,580		4,294,580	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	4,294,580		4,294,580	17.00
18.00	Ancillary services	6,036,190	38,307,022	44,343,212	18.00
19.00	Outpatient services	195,696	8,038,046	8,233,742	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	Other Patient Service Revenue	0	13,790	13,790	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	10,526,466	46,358,858	56,885,324	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		24,584,978		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)		24,584,978		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 15-1335	Period: From 07/01/2021 To 06/30/2022	Worksheet G-3 Date/Time Prepared: 11/28/2022 2:22 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	56,885,324	1.00
2.00	Less contractual allowances and discounts on patients' accounts	34,396,830	2.00
3.00	Net patient revenues (line 1 minus line 2)	22,488,494	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	24,584,978	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-2,096,484	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	-5,127	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	65,241	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	55	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	21,022	22.00
23.00	Governmental appropriations	0	23.00
24.00	Other Operating Income	94,157	24.00
24.01	Other Dietary	8,880	24.01
24.06	Medical Staff Dues Revenue	200	24.06
24.07	IC Rental Income	75,000	24.07
24.50	COVID-19 PHE Funding	3,240,991	24.50
25.00	Total other income (sum of lines 6-24)	3,500,419	25.00
26.00	Total (line 5 plus line 25)	1,403,935	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	1,403,935	29.00