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: 15-0010	Period: From 07/01/2021 To 06/30/2022	Worksheet S Parts I-III Date/Time Prepared: 11/28/2022 1:52 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 11/28/2022 Time: 1:52 pm
2. [ ] Manually prepared cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full 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 KOKOMO (15-0010) 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	Becky Jacobson		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	Becky Jacobson			2
3	Signatory Title	VP - FINANCE			3
4	Date	11/28/2022 01:52:42 PM			4

	Cost Center Description	Title V	Title XVIII		HIT	Title XIX	
			Part A	Part B			
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	269,901	-85,874	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	3,408	0		0	3.00
5.00	Swing Bed - SNF	0	0	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
200.00	Total	0	273,309	-85,874	0	0	200.00

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

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete and review the information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.
Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents , please contact 1-800-MEDICARE.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0010 | Period: From 07/01/2021 To 06/30/2022 | Worksheet S-2 Part I | Date/Time Prepared: 11/28/2022 1:52 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1907 WEST SYCAMORE	PO Box:			1.00
2.00	City: KOKOMO	State: IN	Zip Code: 46901	County: HOWARD	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 KOKOMO	150010	29020	1	07/01/1966	N	P	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF	ASCENSION ST. VINCENT KOKOMO REHAB	15T010	29020	5	07/01/2002	N	P	O	5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From: 1.00	To: 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.	Y	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)	Y	Y		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	Y	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.	3	N		23.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0010 | Period: From 07/01/2021 To 06/30/2022 | Worksheet S-2 Part I Date/Time Prepared: 11/28/2022 1:52 pm

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	419	11	0	15	4,061	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.	14	0	0	0	245		25.00

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

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

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

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	Y	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? 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: 15-0010 | Period: From 07/01/2021 To 06/30/2022 | Worksheet S-2 Part I Date/Time Prepared: 11/28/2022 1:52 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.	Y	Y		60.00
60.01	If line 60 is yes, complete columns 2 and 3 for each program. (see instructions)		23.00	1	60.01

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	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

		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.	Y			75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)	N	N	0	76.00

		1.00	
	Long Term Care Hospital PPS		
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N	80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.	N	81.00
	TEFRA Providers		
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.		86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	N	87.00

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
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?	N		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)			107.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0010	Period: From 07/01/2021 To 06/30/2022	Worksheet S-2 Part I Date/Time Prepared: 11/28/2022 1:52 pm

Line	Description			V	XIX	
				1.00	2.00	
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.					109.00
					1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration)for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.				N	110.00
				1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.			N		111.00
			1.00	2.00	3.00	
112.00	Did this hospital participate in the Pennsylvania Rural Health Model 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:		0	0	904,143	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

		1.00	2.00	
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

	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: ST VINCENT HEALTH	Contractor's Name: WPS	Contractor's Number: 08101	141.00
142.00	Street: 250 W 96TH STREET, SUITE 215	PO Box:		142.00
143.00	City: INDIANAPOLIS	State: IN	Zip Code: 46260	143.00

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

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

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

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

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

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

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)		168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)		168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	9.99	169.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0010 | Period: From 07/01/2021 To 06/30/2022 | Worksheet S-2 Part I Date/Time Prepared: 11/28/2022 1:52 pm

		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: 15-0010 | Period: From 07/01/2021 To 06/30/2022 | Worksheet S-2 Part II Date/Time Prepared: 11/28/2022 1:52 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.	Y		7.00
8.00	Were nursing programs and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00

		Y/N	
		1.00	
	Bad Debts		
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N	13.00
14.00	If line 12 is yes, were patient deductibles and/or 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	10/06/2022	Y	10/06/2022	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-0010	Period: From 07/01/2021 To 06/30/2022	Worksheet S-2 Part II Date/Time Prepared: 11/28/2022 1:52 pm

		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00

		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00

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

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?	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 HEALTH		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	NOT APPLICABLE	JILL.HILL1@ASCENSION.ORG	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-0010	Period: From 07/01/2021 To 06/30/2022	Worksheet S-2 Part II Date/Time Prepared: 11/28/2022 1:52 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.	MANAGER NET REVENUE MANAGEMENT		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: 15-0010 | Period: From 07/01/2021 To 06/30/2022 | Worksheet S-3 Part I Date/Time Prepared: 11/28/2022 1:52 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	98	35,770	0.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		98	35,770	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	13	4,745	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		111	40,515	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	41.00	18	6,570		0	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						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)		129				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)		8	2,920			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: 15-0010 | Period: From 07/01/2021 To 06/30/2022 | Worksheet S-3 Part I Date/Time Prepared: 11/28/2022 1:52 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
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)	4,925	231	14,701			1.00
2.00	HMO and other (see instructions)	5,159	3,997				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	727	245				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	4,925	231	14,701			7.00
8.00	INTENSIVE CARE UNIT	754	190	2,701			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		88	1,315			13.00
14.00	Total (see instructions)	5,679	509	18,717	0.00	456.38	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	1,945	14	3,484	0.00	16.52	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	472.90	27.00
28.00	Observation Bed Days		0	905			28.00
29.00	Ambulance Trips	2,890					29.00
30.00	Employee discount days (see instruction)			190			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	1,477			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: 15-0010 | Period: From 07/01/2021 To 06/30/2022 | Worksheet S-3 Part I | Date/Time Prepared: 11/28/2022 1:52 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	1,250	56	4,640	1.00
2.00	HMO and other (see instructions)			855	1,273		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				20		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	1,250	56	4,640	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	0.00	0	153	1	260	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 WAGE INDEX INFORMATION | Provider CCN: 15-0010 | Period: From 07/01/2021 To 06/30/2022 | Worksheet S-3 Part II Date/Time Prepared: 11/28/2022 1:52 pm

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	38,701,462	3,711	38,705,173	930,619.00	41.59	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		229,819	0	229,819	1,308.00	175.70	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician and Non Physician-Part B		265,477	0	265,477	1,517.00	175.00	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		4,102,642	194,884	4,297,526	89,511.00	48.01	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		2,548,557	0	2,548,557	28,111.51	90.66	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		0	0	0	0.00	0.00	13.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00	14.00
14.01	Home office salaries		8,097,745	0	8,097,745	160,679.00	50.40	14.01
14.02	Related organization salaries		0	0	0	0.00	0.00	14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00	16.01
16.02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.02
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		11,036,766	0	11,036,766			17.00
18.00	Wage-related costs (other) (see instructions)							18.00
19.00	Excluded areas		1,198,718	0	1,198,718			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		65,539	0	65,539			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		75,708	0	75,708			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
25.50	Home office wage-related (core)		3,136,159	0	3,136,159			25.50
25.51	Related organization wage-related (core)		0	0	0			25.51
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0			25.52

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.53	Home office: Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	517,482	-327,078	190,404	286.00	665.75	26.00
27.00	Administrative & General	5.00	1,953,849	-269,410	1,684,439	29,863.00	56.41	27.00
28.00	Administrative & General under contract (see inst.)		758,534	0	758,534	4,749.00	159.72	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	0	0	0	0.00	0.00	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	0	0	0	0.00	0.00	32.00
33.00	Housekeeping under contract (see instructions)		1,266,286	0	1,266,286	54,582.00	23.20	33.00
34.00	Dietary	10.00	0	0	0	0.00	0.00	34.00
35.00	Dietary under contract (see instructions)		893,805	0	893,805	36,392.00	24.56	35.00
36.00	Cafeteria	11.00	0	0	0	0.00	0.00	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,726,777	63,252	1,790,029	44,132.00	40.56	38.00
39.00	Central Services and Supply	14.00	0	0	0	0.00	0.00	39.00
40.00	Pharmacy	15.00	1,606,373	18,624	1,624,997	32,423.00	50.12	40.00
41.00	Medical Records & Medical Records Library	16.00	0	0	0	0.00	0.00	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0010 | Period: From 07/01/2021 To 06/30/2022 | Worksheet S-3 Part III Date/Time Prepared: 11/28/2022 1:52 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		41,354,610	3,711	41,358,321	1,024,825.00	40.36	1.00
2.00	Excluded area salaries (see instructions)		4,102,642	194,884	4,297,526	89,511.00	48.01	2.00
3.00	Subtotal salaries (line 1 minus line 2)		37,251,968	-191,173	37,060,795	935,314.00	39.62	3.00
4.00	Subtotal other wages & related costs (see inst.)		10,646,302	0	10,646,302	188,790.51	56.39	4.00
5.00	Subtotal wage-related costs (see inst.)		14,238,464	0	14,238,464	0.00	38.42	5.00
6.00	Total (sum of lines 3 thru 5)		62,136,734	-191,173	61,945,561	1,124,104.51	55.11	6.00
7.00	Total overhead cost (see instructions)		8,723,106	-514,612	8,208,494	202,427.00	40.55	7.00

HOSPITAL WAGE RELATED COSTS	Provider CCN: 15-0010	Period: From 07/01/2021 To 06/30/2022	Worksheet S-3 Part IV Date/Time Prepared: 11/28/2022 1:52 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	1,890,657	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	224,595	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	4,428,631	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	1,101,580	9.00
10.00	Dental, Hearing and Vision Plan	129,487	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	69,276	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	289,334	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	12,711	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
	TAXES		
17.00	FICA-Employers Portion Only	0	17.00
18.00	Medicare Taxes - Employers Portion Only	2,876,151	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	112	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	14,232	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	11,036,766	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 15-0010 | Period: From 07/01/2021 To 06/30/2022 | Worksheet S-3 Part V Date/Time Prepared: 11/28/2022 1:52 pm

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

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 15-0010	Period: From 07/01/2021 To 06/30/2022	Worksheet S-10 Date/Time Prepared: 11/28/2022 1:52 pm

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.214746	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	13,490,692	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		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	109,432,478	6.00
7.00	Medicaid cost (line 1 times line 6)	23,500,187	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)	10,009,495	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)	10,009,495	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	7,503,104	814,367	8,317,471	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	1,611,262	814,367	2,425,629	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	1,611,262	814,367	2,425,629	23.00

		1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	6,254,458	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	178,787	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	275,056	27.01
28.00	Non-Medicare bad debt expense (see instructions)	5,979,402	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	1,380,322	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	3,805,951	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	13,815,446	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0010 | Period: From 07/01/2021 To 06/30/2022 | Worksheet A | Date/Time Prepared: 11/28/2022 1:52 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		3,689,983	3,689,983	-2,743	3,687,240	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		4,219,523	4,219,523	0	4,219,523	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	517,482	7,460,893	7,978,375	-415,626	7,562,749	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,953,849	45,123,156	47,077,005	-265,784	46,811,221	5.00
7.00	00700	OPERATION OF PLANT	0	4,565,104	4,565,104	0	4,565,104	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	462,705	462,705	8.00
9.00	00900	HOUSEKEEPING	0	2,143,858	2,143,858	-407,969	1,735,889	9.00
10.00	01000	DIETARY	0	2,498,205	2,498,205	-1,070,985	1,427,220	10.00
11.00	01100	CAFETERIA	0	0	0	1,070,985	1,070,985	11.00
13.00	01300	NURSING ADMINISTRATION	1,726,777	401,980	2,128,757	71,557	2,200,314	13.00
15.00	01500	PHARMACY	1,606,373	166,171	1,772,544	5,334,473	7,107,017	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
23.00	02300	ALLIED HEALTH RAD TECH PROGRAM	93,459	35,716	129,175	101,024	230,199	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,243,797	1,747,496	8,991,293	649,129	9,640,422	30.00
31.00	03100	INTENSIVE CARE UNIT	2,368,152	702,846	3,070,998	44,021	3,115,019	31.00
41.00	04100	SUBPROVIDER - IRF	1,133,368	132,474	1,265,842	72,887	1,338,729	41.00
43.00	04300	NURSERY	0	0	0	490,015	490,015	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,167,629	2,363,193	5,530,822	35,583	5,566,405	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,209,422	425,280	2,634,702	-880,043	1,754,659	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,617,348	770,535	2,387,883	-92,365	2,295,518	54.00
54.01	03630	ULTRA SOUND	348,236	39,168	387,404	3,928	391,332	54.01
56.00	05600	RADIOISOTOPE	658,588	368,123	1,026,711	7,418	1,034,129	56.00
57.00	05700	CT SCAN	646,445	78,564	725,009	7,291	732,300	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	327,006	43,463	370,469	3,688	374,157	58.00
59.00	05900	CARDIAC CATHETERIZATION	323	7,730	8,053	4	8,057	59.00
60.00	06000	LABORATORY	166,377	6,333,351	6,499,728	1,877	6,501,605	60.00
65.00	06500	RESPIRATORY THERAPY	1,446,629	298,691	1,745,320	16,316	1,761,636	65.00
66.00	06600	PHYSICAL THERAPY	3,379,864	475,051	3,854,915	-1,165,250	2,689,665	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,006,554	1,006,554	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	164,419	164,419	68.00
69.00	06900	ELECTROCARDIOLOGY	326,334	71,514	397,848	3,681	401,529	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	545,770	169,500	715,270	-3,995	711,275	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	205,242	858,908	1,064,150	2,315	1,066,465	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	3,135,688	3,135,688	0	3,135,688	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	13,585,760	13,585,760	0	13,585,760	73.00
74.00	07400	RENAL DIALYSIS	0	287,633	287,633	0	287,633	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	770,302	65,311	835,613	8,688	844,301	76.00
76.01	03190	CHEMOTHERAPY	727,872	7,539,954	8,267,826	-5,307,905	2,959,921	76.01
76.02	03330	ENDOSCOPY	8,469	21,224	29,693	96	29,789	76.02
76.03	03950	WOUND CARE CENTER	197,830	746,926	944,756	2,231	946,987	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	2,432,704	1,355,596	3,788,300	27,023	3,815,323	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	2,047,427	386,452	2,433,879	23,093	2,456,972	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	37,873,074	112,315,020	150,188,094	-1,664	150,186,430	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	645,352	2,640,064	3,285,416	663	3,286,079	192.00
192.01	19201	ASC MOB	0	-8,706	-8,706	0	-8,706	192.01
192.02	19202	EDUCATION CENTER	0	14,824	14,824	0	14,824	192.02
192.03	19203	MARKETING	0	0	0	0	0	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	FOUNDATION	0	0	0	0	0	194.00
194.01	07951	GIFT SHOP	0	0	0	0	0	194.01
194.02	07952	CLINIC OF HOPE	183,036	35,270	218,306	1,001	219,307	194.02
200.00		TOTAL (SUM OF LINES 118 through 199)	38,701,462	114,996,472	153,697,934	0	153,697,934	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0010 | Period: From 07/01/2021 To 06/30/2022 | Worksheet A | Date/Time Prepared: 11/28/2022 1:52 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
	GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	-536,686	3,150,554	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	4,219,523	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	353,353	7,916,102	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-11,908,166	34,903,055	5.00
7.00	00700	OPERATION OF PLANT	-47,490	4,517,614	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	462,705	8.00
9.00	00900	HOUSEKEEPING	0	1,735,889	9.00
10.00	01000	DIETARY	-75,905	1,351,315	10.00
11.00	01100	CAFETERIA	-368,048	702,937	11.00
13.00	01300	NURSING ADMINISTRATION	-176,530	2,023,784	13.00
15.00	01500	PHARMACY	0	7,107,017	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	16.00
23.00	02300	ALLIED HEALTH RAD TECH PROGRAM	-15,545	214,654	23.00
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-1,093	9,639,329	30.00
31.00	03100	INTENSIVE CARE UNIT	-7,929	3,107,090	31.00
41.00	04100	SUBPROVIDER - IRF	0	1,338,729	41.00
43.00	04300	NURSERY	0	490,015	43.00
	ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-11,981	5,554,424	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	-37	1,754,622	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-177,485	2,118,033	54.00
54.01	03630	ULTRA SOUND	0	391,332	54.01
56.00	05600	RADIOISOTOPE	0	1,034,129	56.00
57.00	05700	CT SCAN	0	732,300	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	374,157	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	8,057	59.00
60.00	06000	LABORATORY	-97,267	6,404,338	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,761,636	65.00
66.00	06600	PHYSICAL THERAPY	-5,766	2,683,899	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,006,554	67.00
68.00	06800	SPEECH PATHOLOGY	0	164,419	68.00
69.00	06900	ELECTROCARDIOLOGY	0	401,529	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	711,275	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,066,465	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	3,135,688	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	13,585,760	73.00
74.00	07400	RENAL DIALYSIS	0	287,633	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	-23,500	820,801	76.00
76.01	03190	CHEMOTHERAPY	-367,131	2,592,790	76.01
76.02	03330	ENDOSCOPY	0	29,789	76.02
76.03	03950	WOUND CARE CENTER	0	946,987	76.03
	OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	-175,000	3,640,323	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
	OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	27,343	2,484,315	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	98.00
	SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-13,614,863	136,571,567	118.00
	NONREIMBURSABLE COST CENTERS				
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	3,286,079	192.00
192.01	19201	ASC MOB	0	-8,706	192.01
192.02	19202	EDUCATION CENTER	0	14,824	192.02
192.03	19203	MARKETING	0	0	192.03
193.00	19300	NONPAID WORKERS	0	0	193.00
194.00	07950	FOUNDATION	0	0	194.00
194.01	07951	GIFT SHOP	0	0	194.01
194.02	07952	CLINIC OF HOPE	0	219,307	194.02
200.00		TOTAL (SUM OF LINES 118 through 199)	-13,614,863	140,083,071	200.00

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - LAUNDRY RECLASS				
1.00	LAUNDRY & LINEN SERVICE	8.00	0	462,705	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
	TOTALS		0	462,705	
	B - NURSERY RECLASS				
1.00	ADULTS & PEDIATRICS	30.00	388,961	74,752	1.00
2.00	NURSERY	43.00	411,023	78,992	2.00
	TOTALS		799,984	153,744	
	C - CAFETERIA RECLASS				
1.00	CAFETERIA	11.00	0	1,070,985	1.00
	TOTALS		0	1,070,985	
	D - PT_OT_SPEECH RECLASS				
1.00	OCCUPATIONAL THERAPY	67.00	883,657	122,897	1.00
2.00	SPEECH PATHOLOGY	68.00	144,344	20,075	2.00
	TOTALS		1,028,001	142,972	
	E - RADIOLOGY TECHNICIAN RECLASS				
1.00	ALLIED HEALTH RAD TECH PROGRAM	23.00	99,970	0	1.00
	TOTALS		99,970	0	
	F - INTEREST EXPENSE A&G				
1.00	ADMINISTRATIVE & GENERAL	5.00	0	2,743	1.00
	TOTALS		0	2,743	
	G - PTO SALARY ACCRUAL				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	88,548	0	1.00
	TOTALS		88,548	0	
	H - STARP SALARY RECLASS				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	1,136	0	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	15,859	0	2.00
3.00	NURSING ADMINISTRATION	13.00	19,476	0	3.00
4.00	PHARMACY	15.00	18,118	0	4.00
5.00	ALLIED HEALTH RAD TECH PROGRAM	23.00	1,054	0	5.00
6.00	ADULTS & PEDIATRICS	30.00	81,689	0	6.00
7.00	INTENSIVE CARE UNIT	31.00	26,621	0	7.00
8.00	SUBPROVIDER - IRF	41.00	12,783	0	8.00
9.00	OPERATING ROOM	50.00	35,330	0	9.00
10.00	DELIVERY ROOM & LABOR ROOM	52.00	24,920	0	10.00
11.00	RADIOLOGY-DIAGNOSTIC	54.00	18,242	0	11.00
12.00	ULTRA SOUND	54.01	3,928	0	12.00
13.00	RADIOISOTOPE	56.00	7,418	0	13.00
14.00	CT SCAN	57.00	7,291	0	14.00
15.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	3,688	0	15.00
16.00	CARDIAC CATHETERIZATION	59.00	4	0	16.00
17.00	RESPIRATORY THERAPY	65.00	16,316	0	17.00
18.00	PHYSICAL THERAPY	66.00	38,121	0	18.00
19.00	ELECTROCARDIOLOGY	69.00	3,681	0	19.00
20.00	ELECTROENCEPHALOGRAPHY	70.00	6,156	0	20.00
21.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	2,315	0	21.00
22.00	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	76.00	8,688	0	22.00
23.00	CHEMOTHERAPY	76.01	7,944	0	23.00
24.00	ENDOSCOPY	76.02	96	0	24.00
25.00	WOUND CARE CENTER	76.03	2,231	0	25.00
26.00	LABORATORY	60.00	1,877	0	26.00
27.00	EMERGENCY	91.00	27,023	0	27.00
28.00	AMBULANCE SERVICES	95.00	23,093	0	28.00
29.00	PHYSICIANS' PRIVATE OFFICES	192.00	663	0	29.00
30.00	CLINIC OF HOPE	194.02	1,001	0	30.00
	TOTALS		416,762	0	
	I - SCK RECLASS				
1.00	ADMINISTRATIVE & GENERAL	5.00	0	883	1.00
2.00	NURSING ADMINISTRATION	13.00	0	8,305	2.00
3.00	ADULTS & PEDIATRICS	30.00	0	26,981	3.00
4.00	INTENSIVE CARE UNIT	31.00	0	7,533	4.00
5.00	SUBPROVIDER - IRF	41.00	0	1,456	5.00
6.00	OPERATING ROOM	50.00	0	4,979	6.00
7.00	DELIVERY ROOM & LABOR ROOM	52.00	0	8,948	7.00
8.00	RADIOLOGY-DIAGNOSTIC	54.00	0	7,057	8.00
9.00	RADIOISOTOPE	56.00	0	5,240	9.00

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
10.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	1,547	10.00
11.00	RESPIRATORY THERAPY	65.00	0	1,407	11.00
12.00	PHYSICAL THERAPY	66.00	0	4,544	12.00
13.00	ELECTROENCEPHALOGRAPHY	70.00	0	1,977	13.00
14.00	CHEMOTHERAPY	76.01	0	1,001	14.00
15.00	LABORATORY	60.00	0	651	15.00
16.00	AMBULANCE SERVICES	95.00	0	1,502	16.00
17.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	826	17.00
	TOTALS		0	84,837	
	J - CHEMOTHERAPY PHARMACEUTICAL RECLASS				
1.00	PHARMACY	15.00	0	5,315,849	1.00
	TOTALS		0	5,315,849	
	K - SYSTEM PROJECTS				
1.00	ADMINISTRATIVE & GENERAL	5.00	674	0	1.00
2.00	NURSING ADMINISTRATION	13.00	52,081	0	2.00
3.00	PHARMACY	15.00	506	0	3.00
4.00	ADULTS & PEDIATRICS	30.00	103,727	0	4.00
5.00	INTENSIVE CARE UNIT	31.00	17,400	0	5.00
6.00	SUBPROVIDER - IRF	41.00	60,104	0	6.00
7.00	DELIVERY ROOM & LABOR ROOM	52.00	48,765	0	7.00
8.00	OPERATING ROOM	50.00	253	0	8.00
9.00	PHYSICAL THERAPY	66.00	1,550	0	9.00
	TOTALS		285,060	0	
500.00	Grand Total: Increases		2,718,325	7,233,835	500.00

RECLASSIFICATIONS | Provider CCN: 15-0010 | Period: From 07/01/2021 To 06/30/2022 | Worksheet A-6 | Date/Time Prepared: 11/28/2022 1:52 pm

	Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	A - LAUNDRY RECLASS					
1.00	HOUSEKEEPING	9.00	0	407,969	0	1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	0	10,637	0	2.00
3.00	PHYSICAL THERAPY	66.00	0	33,948	0	3.00
4.00	ELECTROENCEPHALOGRAPHY	70.00	0	10,151	0	4.00
	TOTALS		0	462,705		
	B - NURSERY RECLASS					
1.00	DELIVERY ROOM & LABOR ROOM	52.00	799,984	153,744	0	1.00
2.00		0.00	0	0	0	2.00
	TOTALS		799,984	153,744		
	C - CAFETERIA RECLASS					
1.00	DIETARY	10.00	0	1,070,985	0	1.00
	TOTALS		0	1,070,985		
	D - PT_OT_SPEECH RECLASS					
1.00	PHYSICAL THERAPY	66.00	1,028,001	142,972	0	1.00
2.00		0.00	0	0	0	2.00
	TOTALS		1,028,001	142,972		
	E - RADIOLOGY TECHNICIAN RECLASS					
1.00	RADIOLOGY-DIAGNOSTIC	54.00	99,970	0	0	1.00
	TOTALS		99,970	0		
	F - INTEREST EXPENSE A&G					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	2,743	11	1.00
	TOTALS		0	2,743		
	G - PTO SALARY ACCRUAL					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	88,548	0	1.00
	TOTALS		0	88,548		
	H - STARP SALARY RECLASS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	416,762	0	0	1.00
2.00		0.00	0	0	0	2.00
3.00		0.00	0	0	0	3.00
4.00		0.00	0	0	0	4.00
5.00		0.00	0	0	0	5.00
6.00		0.00	0	0	0	6.00
7.00		0.00	0	0	0	7.00
8.00		0.00	0	0	0	8.00
9.00		0.00	0	0	0	9.00
10.00		0.00	0	0	0	10.00
11.00		0.00	0	0	0	11.00
12.00		0.00	0	0	0	12.00
13.00		0.00	0	0	0	13.00
14.00		0.00	0	0	0	14.00
15.00		0.00	0	0	0	15.00
16.00		0.00	0	0	0	16.00
17.00		0.00	0	0	0	17.00
18.00		0.00	0	0	0	18.00
19.00		0.00	0	0	0	19.00
20.00		0.00	0	0	0	20.00
21.00		0.00	0	0	0	21.00
22.00		0.00	0	0	0	22.00
23.00		0.00	0	0	0	23.00
24.00		0.00	0	0	0	24.00
25.00		0.00	0	0	0	25.00
26.00		0.00	0	0	0	26.00
27.00		0.00	0	0	0	27.00
28.00		0.00	0	0	0	28.00
29.00		0.00	0	0	0	29.00
30.00		0.00	0	0	0	30.00
	TOTALS		416,762	0		
	I - SCK RECLASS					
1.00	ADMINISTRATIVE & GENERAL	5.00	883	0	0	1.00
2.00	NURSING ADMINISTRATION	13.00	8,305	0	0	2.00
3.00	ADULTS & PEDIATRICS	30.00	26,981	0	0	3.00
4.00	INTENSIVE CARE UNIT	31.00	7,533	0	0	4.00
5.00	SUBPROVIDER - IRF	41.00	1,456	0	0	5.00
6.00	OPERATING ROOM	50.00	4,979	0	0	6.00
7.00	DELIVERY ROOM & LABOR ROOM	52.00	8,948	0	0	7.00
8.00	RADIOLOGY-DIAGNOSTIC	54.00	7,057	0	0	8.00
9.00	RADIOISOTOPE	56.00	5,240	0	0	9.00
10.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	1,547	0	0	10.00
11.00	RESPIRATORY THERAPY	65.00	1,407	0	0	11.00
12.00	PHYSICAL THERAPY	66.00	4,544	0	0	12.00
13.00	ELECTROENCEPHALOGRAPHY	70.00	1,977	0	0	13.00
14.00	CHEMOTHERAPY	76.01	1,001	0	0	14.00

RECLASSIFICATIONS | Provider CCN: 15-0010 | Period: From 07/01/2021 To 06/30/2022 | Worksheet A-6 | Date/Time Prepared: 11/28/2022 1:52 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
15.00	LABORATORY	60.00	651	0	0		15.00
16.00	AMBULANCE SERVICES	95.00	1,502	0	0		16.00
17.00	PHYSICIANS' PRIVATE OFFICES	192.00	826	0	0		17.00
	TOTALS		84,837	0			
	J - CHEMOTHERAPY PHARMACEUTICAL RECLASS						
1.00	CHEMOTHERAPY	76.01	0	5,315,849	0		1.00
	TOTALS		0	5,315,849			
	K - SYSTEM PROJECTS						
1.00	ADMINISTRATIVE & GENERAL	5.00	285,060	0	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
	TOTALS		285,060	0			
500.00	Grand Total: Decreases		2,714,614	7,237,546			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0010 | Period: From 07/01/2021 To 06/30/2022 | Worksheet A-7 Part I Date/Time Prepared: 11/28/2022 1:52 pm

		Beginning Balances	Acquisitions Purchases	Acquisitions Donation	Acquisitions Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	671,919	0	0	0	0	1.00
2.00	Land Improvements	1,934,722	381,820	0	381,820	0	2.00
3.00	Buildings and Fixtures	54,713,594	7,158	0	7,158	132,717	3.00
4.00	Building Improvements	27,964,926	1,018,285	0	1,018,285	58,264	4.00
5.00	Fixed Equipment	21,083,741	0	0	0	364,759	5.00
6.00	Movable Equipment	53,435,683	2,129,533	0	2,129,533	2,983,322	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	159,804,585	3,536,796	0	3,536,796	3,539,062	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	159,804,585	3,536,796	0	3,536,796	3,539,062	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	671,919	0	1.00
2.00	Land Improvements	2,316,542	0	2.00
3.00	Buildings and Fixtures	54,588,035	0	3.00
4.00	Building Improvements	28,924,947	0	4.00
5.00	Fixed Equipment	20,718,982	0	5.00
6.00	Movable Equipment	52,581,894	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	159,802,319	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	159,802,319	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0010 | Period: From 07/01/2021 To 06/30/2022 | Worksheet A-7 Part II Date/Time Prepared: 11/28/2022 1:52 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	2,719,903	395,474	536,686	0	37,920	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	3,571,014	427,009	0	0	9,463	2.00
3.00	Total (sum of lines 1-2)	6,290,917	822,483	536,686	0	47,383	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	3,689,983	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	212,037	4,219,523	2.00
3.00	Total (sum of lines 1-2)	212,037	7,909,506	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0010 | Period: From 07/01/2021 To 06/30/2022 | Worksheet A-7 Part III Date/Time Prepared: 11/28/2022 1:52 pm

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1.000000	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0.000000	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	2,719,903	395,474	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	3,571,014	427,009	2.00
3.00	Total (sum of lines 1-2)	0	0	0	6,290,917	822,483	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	-2,743	0	37,920	0	3,150,554	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	9,463	212,037	4,219,523	2.00
3.00	Total (sum of lines 1-2)	-2,743	0	47,383	212,037	7,370,077	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0010 | Period: From 07/01/2021 To 06/30/2022 | Worksheet A-8 | Date/Time Prepared: 11/28/2022 1:52 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
				Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-530,596	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	-55,951	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)	A	-9,674	ADMINISTRATIVE & GENERAL	5.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-744,346			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	5,333,962			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-368,048	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	B	-1,066	ADMINISTRATIVE & GENERAL	5.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines	B	-1,811	DIETARY	10.00	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	LOBBYING EXPENSE OFFSET	A	-1,774	ADMINISTRATIVE & GENERAL	5.00	0	33.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0010 | Period: From 07/01/2021 To 06/30/2022 | Worksheet A-8 | Date/Time Prepared: 11/28/2022 1:52 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
				Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.01	BUILDING RENTAL INCOME CHEMOTHERAPY	B	-14,954	CHEMOTHERAPY	76.01	0	33.01
33.02	BUILDING RENTAL INCOME PROPERTY MGMT	B	-16,298	OPERATION OF PLANT	7.00	0	33.02
33.03	MISC. INCOME ADMIN & GENERAL	B	-191,425	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04	MISC. INCOME HUMAN RESOURCES	B	-25	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.04
33.05	MISC. INCOME RECYCLING	B	-2,578	OPERATION OF PLANT	7.00	0	33.05
33.06	MISC. INCOME MEDICAL AFFAIRS	B	-30	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07	MISC. INCOME MEDICAL AFFAIRS DUES	B	-14,950	ADMINISTRATIVE & GENERAL	5.00	0	33.07
33.08	MISC. INCOME SOUTHWAY REHAB	B	-3,566	PHYSICAL THERAPY	66.00	0	33.08
33.09	MISC. INCOME FORESTPARK REHAB	B	-2,200	PHYSICAL THERAPY	66.00	0	33.09
33.10	MISC. INCOME PATIENT INT, INC	B	-7,378	ADMINISTRATIVE & GENERAL	5.00	0	33.10
33.11	MISC. INCOME RAD TECH TUITION	B	-15,545	ALLIED HEALTH RAD TECH PROGRAM	23.00	0	33.11
33.12	MISC. INCOME CHEMOTHERAPY	B	-348,233	CHEMOTHERAPY	76.01	0	33.12
33.13	MISC. INCOME MEALS ON WHEELS	B	-74,092	DIETARY	10.00	0	33.13
33.14	MISC. INCOME IC RENTAL INCOME	B	-24,518	OPERATION OF PLANT	7.00	0	33.14
34.00	PROVIDER TAX EXPENSE	A	-10,668,601	ADMINISTRATIVE & GENERAL	5.00	0	34.00
34.01	PHYSICIAN FUND EXPENSE	A	-5,780,937	ADMINISTRATIVE & GENERAL	5.00	0	34.01
34.02	MID LEVEL PROVIDER OFFSET	A	-1,093	ADULTS & PEDIATRICS	30.00	0	34.02
34.03	MID LEVEL PROVIDER OFFSET	A	-7,929	INTENSIVE CARE UNIT	31.00	0	34.03
34.04	MID LEVEL PROVIDER OFFSET	A	-23,500	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	76.00	0	34.04
34.05	MID LEVEL PROVIDER OFFSET	A	-36,785	LABORATORY	60.00	0	34.05
34.06	ANDERSON AMBULANCE EXPENSES	A	27,717	AMBULANCE SERVICES	95.00	0	34.06
35.00	TELEVISION EXPENSE UTILITIES	A	-4,096	OPERATION OF PLANT	7.00	0	35.00
35.01	BAD DEBT NON-PATIENT DIETARY	A	-2	DIETARY	10.00	0	35.01
35.02	BAD DEBT NON-PATIENT CHEMOTHERAPY	A	-3,650	CHEMOTHERAPY	76.01	0	35.02
35.03	ENTERTAINMENT ADMINISTRATION	A	-1,635	ADMINISTRATIVE & GENERAL	5.00	0	35.03
35.04	ENTERTAINMENT LABOR AND DELIVERY	A	-37	DELIVERY ROOM & LABOR ROOM	52.00	0	35.04
35.05	ENTERTAINMENT CHEMOTHERAPY	A	-249	CHEMOTHERAPY	76.01	0	35.05
35.06	ENTERTAINMENT AMBULANCE	A	-374	AMBULANCE SERVICES	95.00	0	35.06
35.07	MARKETING INFUSION SERVICES	A	-45	CHEMOTHERAPY	76.01	0	35.07
35.08	DONATIONS	A	-8,551	NURSING ADMINISTRATION	13.00	0	35.08
35.09	DONATIONS	A	-10,000	NURSING ADMINISTRATION	13.00	0	35.09
35.10	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	35.10
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-13,614,863				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: 15-0010	Period: From 07/01/2021 To 06/30/2022	Worksheet A-8-1 Date/Time Prepared: 11/28/2022 1:52 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	HEALTH INSURANCE	6,258,826	5,905,448	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE CAPITAL	2,031,873	0	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE INTEREST EXPENSE	53,208	0	3.00
3.01	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE INTEREST EXPENSE	320	0	3.01
3.02	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE OTHER	31,244,534	27,655,412	3.02
3.03	4.00	EMPLOYEE BENEFITS DEPARTMENT	SVH CHARGEBACK	2,468	2,468	3.03
3.04	15.00	PHARMACY	SVH CHARGEBACK	-24,000	-24,000	3.04
3.05	23.00	ALLIED HEALTH RAD TECH PROGR	SVH CHARGEBACK	28,370	28,370	3.05
3.06	54.00	RADIOLOGY-DIAGNOSTIC	SVH CHARGEBACK	41,540	41,540	3.06
3.07	56.00	RADIOISOTOPE	SVH CHARGEBACK	10,437	10,437	3.07
3.08	59.00	CARDIAC CATHETERIZATION	SVH CHARGEBACK	5,000	5,000	3.08
3.09	69.00	ELECTROCARDIOLOGY	SVH CHARGEBACK	5,000	5,000	3.09
3.10	91.00	EMERGENCY	SVH CHARGEBACK	100	100	3.10
3.11	192.00	PHYSICIANS' PRIVATE OFFICES	SVH CHARGEBACK	1,843,224	1,843,224	3.11
3.12	5.00	ADMINISTRATIVE & GENERAL	INTEREST EXPENSE A&G	2,743	0	3.12
3.13	1.00	CAP REL COSTS-BLDG & FIXT	INTEREST EXPENSE	530,596	536,686	3.13
4.00	5.00	ADMINISTRATIVE & GENERAL	TRG ADMINISTRATIVE FEES	-505,863	0	4.00
4.01	5.00	ADMINISTRATIVE & GENERAL	TRG ADMINISTRATIVE FEES	-26,750	0	4.01
4.02	13.00	NURSING ADMINISTRATION	TRG ADMINISTRATIVE FEES	-157,979	0	4.02
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			41,343,647	36,009,685	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.

	Symbol (1)	Name	Percentage of Ownership	Related Organization(s) and/or Home Office 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.

	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	
6.00	B		0.00	SVH HOME OFFICE	100.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 15-0010	Period: From 07/01/2021 To 06/30/2022	Worksheet A-8-1 Date/Time Prepared: 11/28/2022 1:52 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.	
	6.00	7.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:		
1.00	353,378	0	1.00
2.00	2,031,873	0	2.00
3.00	53,208	0	3.00
3.01	320	0	3.01
3.02	3,589,122	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	0	0	3.07
3.08	0	0	3.08
3.09	0	0	3.09
3.10	0	0	3.10
3.11	0	0	3.11
3.12	2,743	0	3.12
3.13	-6,090	11	3.13
4.00	-505,863	0	4.00
4.01	-26,750	0	4.01
4.02	-157,979	0	4.02
5.00	5,333,962		5.00

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

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

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

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

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

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-0010 | Period: From 07/01/2021 To 06/30/2022 | Worksheet A-8-2 | Date/Time Prepared: 11/28/2022 1:52 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	459,212	264,593	194,619	211,500	1,375	1.00
2.00	50.00	OPERATING ROOM	35,200	0	35,200	246,400	196	2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	177,485	177,485	0	0	0	3.00
4.00	56.00	RADIOISOTOPE	-25,250	0	-25,250	0	-114	4.00
5.00	91.00	EMERGENCY	175,000	175,000	0	0	0	5.00
6.00	60.00	LABORATORY	157,487	0	157,487	211,500	954	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			979,134	617,078	362,056		2,411	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	139,814	6,991	0	0	0	1.00
2.00	50.00	OPERATING ROOM	23,219	1,161	0	0	0	2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	3.00
4.00	56.00	RADIOISOTOPE	0	0	0	0	0	4.00
5.00	91.00	EMERGENCY	0	0	0	0	0	5.00
6.00	60.00	LABORATORY	97,005	4,850	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			260,038	13,002	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	139,814	54,805	319,398	1.00
2.00	50.00	OPERATING ROOM	0	23,219	11,981	11,981	2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	177,485	3.00
4.00	56.00	RADIOISOTOPE	0	0	0	0	4.00
5.00	91.00	EMERGENCY	0	0	0	175,000	5.00
6.00	60.00	LABORATORY	0	97,005	60,482	60,482	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	260,038	127,268	744,346	200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0010 | Period: From 07/01/2021 To 06/30/2022 | Worksheet B Part I | Date/Time Prepared: 11/28/2022 1:52 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	3,150,554	3,150,554				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	4,219,523		4,219,523			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	7,916,102	121,865	0	8,037,967		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	34,903,055	476,368	41,205	351,539	35,772,167	5.00
7.00	00700	OPERATION OF PLANT	4,517,614	437,176	63,822	0	5,018,612	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	462,705	4,924	0	0	467,629	8.00
9.00	00900	HOUSEKEEPING	1,735,889	19,154	0	0	1,755,043	9.00
10.00	01000	DIETARY	1,351,315	49,478	14,457	0	1,415,250	10.00
11.00	01100	CAFETERIA	702,937	59,982	12,078	0	774,997	11.00
13.00	01300	NURSING ADMINISTRATION	2,023,784	51,912	157,697	373,575	2,606,968	13.00
15.00	01500	PHARMACY	7,107,017	30,409	8,380	339,134	7,484,940	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	23,261	2,736	0	25,997	16.00
23.00	02300	ALLIED HEALTH RAD TECH PROGRAM	214,654	8,517	0	40,588	263,759	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,639,329	279,891	152,177	1,626,021	11,697,418	30.00
31.00	03100	INTENSIVE CARE UNIT	3,107,090	53,575	95,587	501,844	3,758,096	31.00
41.00	04100	SUBPROVIDER - IRF	1,338,729	128,976	589	251,439	1,719,733	41.00
43.00	04300	NURSERY	490,015	15,295	22,560	85,780	613,650	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,554,424	310,358	632,169	667,465	7,164,416	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,754,622	31,027	77,363	307,657	2,170,669	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,118,033	226,440	779,936	319,008	3,443,417	54.00
54.01	03630	ULTRA SOUND	391,332	0	124,278	73,496	589,106	54.01
56.00	05600	RADIOISOTOPE	1,034,129	19,012	580,667	137,901	1,771,709	56.00
57.00	05700	CT SCAN	732,300	0	0	136,433	868,733	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	374,157	0	283,354	68,692	726,203	58.00
59.00	05900	CARDIAC CATHETERIZATION	8,057	3,802	16,698	68	28,625	59.00
60.00	06000	LABORATORY	6,404,338	75,096	3,579	34,978	6,517,991	60.00
65.00	06500	RESPIRATORY THERAPY	1,761,636	11,759	41,625	305,020	2,120,040	65.00
66.00	06600	PHYSICAL THERAPY	2,683,899	68,585	22,887	498,160	3,273,531	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,006,554	29,430	8,600	184,417	1,229,001	67.00
68.00	06800	SPEECH PATHOLOGY	164,419	9,886	1,405	30,124	205,834	68.00
69.00	06900	ELECTROCARDIOLOGY	401,529	38,052	135,673	68,873	644,127	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	711,275	25,932	20,749	114,773	872,729	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,066,465	40,961	95,254	43,317	1,245,997	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,135,688	0	0	0	3,135,688	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	13,585,760	0	0	0	13,585,760	73.00
74.00	07400	RENAL DIALYSIS	287,633	0	0	0	287,633	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	820,801	43,642	14,749	162,574	1,041,766	76.00
76.01	03190	CHEMOTHERAPY	2,592,790	0	572,364	153,354	3,318,508	76.01
76.02	03330	ENDOSCOPY	29,789	0	7,846	1,787	39,422	76.02
76.03	03950	WOUND CARE CENTER	946,987	28,518	9,715	41,752	1,026,972	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	3,640,323	183,844	123,442	513,340	4,460,949	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	2,484,315	37,719	82,467	431,800	3,036,301	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	136,571,567	2,944,846	4,206,108	7,864,909	136,179,386	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,286,079	194,215	2,534	134,650	3,617,478	192.00
192.01	19201	ASC MOB	-8,706	0	9,793	0	1,087	192.01
192.02	19202	EDUCATION CENTER	14,824	0	0	0	14,824	192.02
192.03	19203	MARKETING	0	0	0	0	0	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	FOUNDATION	0	1,711	0	0	1,711	194.00
194.01	07951	GIFT SHOP	0	9,782	0	0	9,782	194.01
194.02	07952	CLINIC OF HOPE	219,307	0	1,088	38,408	258,803	194.02
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	140,083,071	3,150,554	4,219,523	8,037,967	140,083,071	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0010 | Period: From 07/01/2021 To 06/30/2022 | Worksheet B Part I Date/Time Prepared: 11/28/2022 1:52 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	35,772,167					5.00
7.00	00700	OPERATION OF PLANT	1,721,073	6,739,685				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	160,368	15,690	643,687			8.00
9.00	00900	HOUSEKEEPING	601,871	61,033	197,648	2,615,595		9.00
10.00	01000	DIETARY	485,343	157,657	0	0	2,058,250	10.00
11.00	01100	CAFETERIA	265,776	191,127	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	894,028	165,411	0	2,003	0	13.00
15.00	01500	PHARMACY	2,566,870	96,896	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	8,915	74,118	0	668	0	16.00
23.00	02300	ALLIED HEALTH RAD TECH PROGRAM	90,453	27,139	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,011,489	891,844	205,570	761,045	1,362,927	30.00
31.00	03100	INTENSIVE CARE UNIT	1,288,794	170,712	54,806	200,275	250,409	31.00
41.00	04100	SUBPROVIDER - IRF	589,762	410,968	5,384	200,275	323,001	41.00
43.00	04300	NURSERY	210,444	48,736	8,407	103,395	121,913	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,456,950	988,921	6,441	400,551	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	744,405	98,865	22,790	277,128	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,180,879	721,526	15,086	40,723	0	54.00
54.01	03630	ULTRA SOUND	202,027	0	3,968	8,679	0	54.01
56.00	05600	RADIOISOTOPE	607,586	60,579	0	30,041	0	56.00
57.00	05700	CT SCAN	297,922	0	7,221	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	249,043	0	1,894	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	9,817	12,116	0	13,352	0	59.00
60.00	06000	LABORATORY	2,235,267	239,287	475	82,780	0	60.00
65.00	06500	RESPIRATORY THERAPY	727,042	37,468	436	4,006	0	65.00
66.00	06600	PHYSICAL THERAPY	1,122,618	218,539	0	13,352	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	421,471	93,776	0	1,335	0	67.00
68.00	06800	SPEECH PATHOLOGY	70,588	31,501	403	8,679	0	68.00
69.00	06900	ELECTROCARDIOLOGY	220,896	121,249	0	5,341	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	299,292	82,630	0	34,047	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	427,300	130,517	10,152	74,769	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,075,347	0	45	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,659,066	0	71	30,041	0	73.00
74.00	07400	RENAL DIALYSIS	98,640	0	0	13,352	0	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	357,261	139,059	3,626	26,703	0	76.00
76.01	03190	CHEMOTHERAPY	1,138,042	0	0	0	0	76.01
76.02	03330	ENDOSCOPY	13,519	0	0	0	0	76.02
76.03	03950	WOUND CARE CENTER	352,188	90,868	0	42,725	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	1,529,829	585,799	98,435	240,330	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,041,263	120,189	829	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	34,433,444	6,084,220	643,687	2,615,595	2,058,250	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,240,571	618,845	0	0	0	192.00
192.01	19201	ASC MOB	373	0	0	0	0	192.01
192.02	19202	EDUCATION CENTER	5,084	0	0	0	0	192.02
192.03	19203	MARKETING	0	0	0	0	0	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	FOUNDATION	587	5,452	0	0	0	194.00
194.01	07951	GIFT SHOP	3,355	31,168	0	0	0	194.01
194.02	07952	CLINIC OF HOPE	88,753	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	35,772,167	6,739,685	643,687	2,615,595	2,058,250	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0010 | Period: From 07/01/2021 To 06/30/2022 | Worksheet B Part I | Date/Time Prepared: 11/28/2022 1:52 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	PHARMACY	MEDICAL RECORDS & LIBRARY	ALLIED HEALTH RAD TECH PROGRAM	
			11.00	13.00	15.00	16.00	23.00	
		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	1,231,900					11.00
13.00	01300	NURSING ADMINISTRATION	66,943	3,735,353				13.00
15.00	01500	PHARMACY	49,182	21,145	10,219,033			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	109,698		16.00
23.00	02300	ALLIED HEALTH RAD TECH PROGRAM	3,481	0	0	0	384,832	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	293,201	1,348,091	0	5,839	0	30.00
31.00	03100	INTENSIVE CARE UNIT	74,899	404,151	0	2,296	0	31.00
41.00	04100	SUBPROVIDER - IRF	52,266	307,613	0	1,269	0	41.00
43.00	04300	NURSERY	11,105	105,330	0	473	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	103,483	509,552	0	16,671	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	48,495	361,180	0	3,273	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	61,694	13,345	0	4,063	117,213	54.00
54.01	03630	ULTRA SOUND	8,657	0	0	1,409	40,660	54.01
56.00	05600	RADIOISOTOPE	27,826	20,049	0	4,482	129,335	56.00
57.00	05700	CT SCAN	19,610	0	0	2,778	80,145	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	10,439	0	0	606	17,479	58.00
59.00	05900	CARDIAC CATHETERIZATION	9	3,404	0	6	0	59.00
60.00	06000	LABORATORY	10,456	622	0	16,018	0	60.00
65.00	06500	RESPIRATORY THERAPY	49,132	23,363	0	2,864	0	65.00
66.00	06600	PHYSICAL THERAPY	97,338	0	0	2,489	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	36,642	0	0	918	0	67.00
68.00	06800	SPEECH PATHOLOGY	5,986	0	0	150	0	68.00
69.00	06900	ELECTROCARDIOLOGY	11,733	24,815	0	2,552	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	23,232	0	0	1,322	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	13,599	0	0	3,334	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	2,246	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	10,219,033	12,941	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	270	0	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	31,415	13,461	0	786	0	76.00
76.01	03190	CHEMOTHERAPY	28,311	85,625	0	1,910	0	76.01
76.02	03330	ENDOSCOPY	296	11,010	0	10	0	76.02
76.03	03950	WOUND CARE CENTER	8,684	29,918	0	3,003	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	76,373	402,160	0	12,212	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	3,508	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,224,487	3,684,834	10,219,033	109,698	384,832	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	36,980	0	0	0	192.00
192.01	19201	ASC MOB	0	0	0	0	0	192.01
192.02	19202	EDUCATION CENTER	0	0	0	0	0	192.02
192.03	19203	MARKETING	0	0	0	0	0	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	FOUNDATION	0	0	0	0	0	194.00
194.01	07951	GIFT SHOP	0	0	0	0	0	194.01
194.02	07952	CLINIC OF HOPE	7,413	13,539	0	0	0	194.02
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,231,900	3,735,353	10,219,033	109,698	384,832	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0010 | Period: From 07/01/2021 To 06/30/2022 | Worksheet B Part I | Date/Time Prepared: 11/28/2022 1:52 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
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
23.00	02300	ALLIED HEALTH RAD TECH PROGRAM					23.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	20,577,424	0	20,577,424		30.00
31.00	03100	INTENSIVE CARE UNIT	6,204,438	0	6,204,438		31.00
41.00	04100	SUBPROVIDER - IRF	3,610,271	0	3,610,271		41.00
43.00	04300	NURSERY	1,223,453	0	1,223,453		43.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	11,646,985	0	11,646,985		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,726,805	0	3,726,805		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,597,946	0	5,597,946		54.00
54.01	03630	ULTRA SOUND	854,506	0	854,506		54.01
56.00	05600	RADIOISOTOPE	2,651,607	0	2,651,607		56.00
57.00	05700	CT SCAN	1,276,409	0	1,276,409		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,005,664	0	1,005,664		58.00
59.00	05900	CARDIAC CATHETERIZATION	67,329	0	67,329		59.00
60.00	06000	LABORATORY	9,102,896	0	9,102,896		60.00
65.00	06500	RESPIRATORY THERAPY	2,964,351	0	2,964,351		65.00
66.00	06600	PHYSICAL THERAPY	4,727,867	0	4,727,867		66.00
67.00	06700	OCCUPATIONAL THERAPY	1,783,143	0	1,783,143		67.00
68.00	06800	SPEECH PATHOLOGY	323,141	0	323,141		68.00
69.00	06900	ELECTROCARDIOLOGY	1,030,713	0	1,030,713		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,313,252	0	1,313,252		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,905,668	0	1,905,668		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,213,326	0	4,213,326		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	28,506,912	0	28,506,912		73.00
74.00	07400	RENAL DIALYSIS	399,895	0	399,895		74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1,614,077	0	1,614,077		76.00
76.01	03190	CHEMOTHERAPY	4,572,396	0	4,572,396		76.01
76.02	03330	ENDOSCOPY	64,257	0	64,257		76.02
76.03	03950	WOUND CARE CENTER	1,554,358	0	1,554,358		76.03
		OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	7,406,087	0	7,406,087		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	4,202,090	0	4,202,090		95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0		98.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	134,127,266	0	134,127,266		118.00
		NONREIMBURSABLE COST CENTERS					
192.00	19200	PHYSICIANS' PRIVATE OFFICES	5,513,874	0	5,513,874		192.00
192.01	19201	ASC MOB	1,460	0	1,460		192.01
192.02	19202	EDUCATION CENTER	19,908	0	19,908		192.02
192.03	19203	MARKETING	0	0	0		192.03
193.00	19300	NONPAID WORKERS	0	0	0		193.00
194.00	07950	FOUNDATION	7,750	0	7,750		194.00
194.01	07951	GIFT SHOP	44,305	0	44,305		194.01
194.02	07952	CLINIC OF HOPE	368,508	0	368,508		194.02
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)	140,083,071	0	140,083,071		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0010 | Period: From 07/01/2021 To 06/30/2022 | Worksheet B Part II | Date/Time Prepared: 11/28/2022 1:52 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	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	121,865	0	121,865	121,865	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,031,873	476,368	41,205	2,549,446	5,330	5.00
7.00	00700	OPERATION OF PLANT	0	437,176	63,822	500,998	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	4,924	0	4,924	0	8.00
9.00	00900	HOUSEKEEPING	0	19,154	0	19,154	0	9.00
10.00	01000	DIETARY	0	49,478	14,457	63,935	0	10.00
11.00	01100	CAFETERIA	0	59,982	12,078	72,060	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	51,912	157,697	209,609	5,664	13.00
15.00	01500	PHARMACY	0	30,409	8,380	38,789	5,141	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	23,261	2,736	25,997	0	16.00
23.00	02300	ALLIED HEALTH RAD TECH PROGRAM	0	8,517	0	8,517	615	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	279,891	152,177	432,068	24,659	30.00
31.00	03100	INTENSIVE CARE UNIT	0	53,575	95,587	149,162	7,608	31.00
41.00	04100	SUBPROVIDER - IRF	0	128,976	589	129,565	3,812	41.00
43.00	04300	NURSERY	0	15,295	22,560	37,855	1,300	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	310,358	632,169	942,527	10,119	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	31,027	77,363	108,390	4,664	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	226,440	779,936	1,006,376	4,836	54.00
54.01	03630	ULTRA SOUND	0	0	124,278	124,278	1,114	54.01
56.00	05600	RADIOISOTOPE	0	19,012	580,667	599,679	2,091	56.00
57.00	05700	CT SCAN	0	0	0	0	2,068	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	283,354	283,354	1,041	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	3,802	16,698	20,500	1	59.00
60.00	06000	LABORATORY	0	75,096	3,579	78,675	530	60.00
65.00	06500	RESPIRATORY THERAPY	0	11,759	41,625	53,384	4,624	65.00
66.00	06600	PHYSICAL THERAPY	0	68,585	22,887	91,472	7,552	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	29,430	8,600	38,030	2,796	67.00
68.00	06800	SPEECH PATHOLOGY	0	9,886	1,405	11,291	457	68.00
69.00	06900	ELECTROCARDIOLOGY	0	38,052	135,673	173,725	1,044	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	25,932	20,749	46,681	1,740	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	40,961	95,254	136,215	657	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	43,642	14,749	58,391	2,465	76.00
76.01	03190	CHEMOTHERAPY	0	0	572,364	572,364	2,325	76.01
76.02	03330	ENDOSCOPY	0	0	7,846	7,846	27	76.02
76.03	03950	WOUND CARE CENTER	0	28,518	9,715	38,233	633	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	183,844	123,442	307,286	7,783	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	37,719	82,467	120,186	6,546	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,031,873	2,944,846	4,206,108	9,182,827	119,242	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	194,215	2,534	196,749	2,041	192.00
192.01	19201	ASC MOB	0	0	9,793	9,793	0	192.01
192.02	19202	EDUCATION CENTER	0	0	0	0	0	192.02
192.03	19203	MARKETING	0	0	0	0	0	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	FOUNDATION	0	1,711	0	1,711	0	194.00
194.01	07951	GIFT SHOP	0	9,782	0	9,782	0	194.01
194.02	07952	CLINIC OF HOPE	0	0	1,088	1,088	582	194.02
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	2,031,873	3,150,554	4,219,523	9,401,950	121,865	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0010 | Period: From 07/01/2021 To 06/30/2022 | Worksheet B Part II Date/Time Prepared: 11/28/2022 1:52 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	2,554,776					5.00
7.00	00700	OPERATION OF PLANT	122,916	623,914				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	11,453	1,452	17,829			8.00
9.00	00900	HOUSEKEEPING	42,985	5,650	5,474	73,263		9.00
10.00	01000	DIETARY	34,662	14,595	0	0	113,192	10.00
11.00	01100	CAFETERIA	18,981	17,693	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	63,850	15,313	0	56	0	13.00
15.00	01500	PHARMACY	183,321	8,970	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	637	6,861	0	19	0	16.00
23.00	02300	ALLIED HEALTH RAD TECH PROGRAM	6,460	2,512	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	286,493	82,561	5,697	21,317	74,953	30.00
31.00	03100	INTENSIVE CARE UNIT	92,043	15,803	1,518	5,610	13,771	31.00
41.00	04100	SUBPROVIDER - IRF	42,120	38,045	149	5,610	17,763	41.00
43.00	04300	NURSERY	15,030	4,512	233	2,896	6,705	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	175,471	91,549	178	11,219	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	53,164	9,152	631	7,762	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	84,336	66,794	418	1,141	0	54.00
54.01	03630	ULTRA SOUND	14,428	0	110	243	0	54.01
56.00	05600	RADIOISOTOPE	43,393	5,608	0	841	0	56.00
57.00	05700	CT SCAN	21,277	0	200	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	17,786	0	52	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	701	1,122	0	374	0	59.00
60.00	06000	LABORATORY	159,639	22,152	13	2,319	0	60.00
65.00	06500	RESPIRATORY THERAPY	51,924	3,469	12	112	0	65.00
66.00	06600	PHYSICAL THERAPY	80,175	20,231	0	374	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	30,101	8,681	0	37	0	67.00
68.00	06800	SPEECH PATHOLOGY	5,041	2,916	11	243	0	68.00
69.00	06900	ELECTROCARDIOLOGY	15,776	11,224	0	150	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	21,375	7,649	0	954	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	30,517	12,082	281	2,094	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	76,799	0	1	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	332,733	0	2	841	0	73.00
74.00	07400	RENAL DIALYSIS	7,045	0	0	374	0	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	25,515	12,873	100	748	0	76.00
76.01	03190	CHEMOTHERAPY	81,277	0	0	0	0	76.01
76.02	03330	ENDOSCOPY	966	0	0	0	0	76.02
76.03	03950	WOUND CARE CENTER	25,153	8,412	0	1,197	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	109,258	54,229	2,726	6,732	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	74,365	11,126	23	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,459,166	563,236	17,829	73,263	113,192	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	88,599	57,288	0	0	0	192.00
192.01	19201	ASC MOB	27	0	0	0	0	192.01
192.02	19202	EDUCATION CENTER	363	0	0	0	0	192.02
192.03	19203	MARKETING	0	0	0	0	0	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	FOUNDATION	42	505	0	0	0	194.00
194.01	07951	GIFT SHOP	240	2,885	0	0	0	194.01
194.02	07952	CLINIC OF HOPE	6,339	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	2,554,776	623,914	17,829	73,263	113,192	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0010 | Period: From 07/01/2021 To 06/30/2022 | Worksheet B Part II Date/Time Prepared: 11/28/2022 1:52 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	PHARMACY	MEDICAL RECORDS & LIBRARY	ALLIED HEALTH RAD TECH PROGRAM	
			11.00	13.00	15.00	16.00	23.00	
		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	108,734					11.00
13.00	01300	NURSING ADMINISTRATION	5,909	300,401				13.00
15.00	01500	PHARMACY	4,341	1,701	242,263			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	33,514		16.00
23.00	02300	ALLIED HEALTH RAD TECH PROGRAM	307	0	0	0	18,411	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	25,880	108,414	0	1,792		30.00
31.00	03100	INTENSIVE CARE UNIT	6,611	32,502	0	705		31.00
41.00	04100	SUBPROVIDER - IRF	4,613	24,739	0	389		41.00
43.00	04300	NURSERY	980	8,471	0	145		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	9,134	40,979	0	4,972		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,280	29,046	0	1,004		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,445	1,073	0	1,246		54.00
54.01	03630	ULTRA SOUND	764	0	0	432		54.01
56.00	05600	RADIOISOTOPE	2,456	1,612	0	1,375		56.00
57.00	05700	CT SCAN	1,731	0	0	852		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	921	0	0	186		58.00
59.00	05900	CARDIAC CATHETERIZATION	1	274	0	2		59.00
60.00	06000	LABORATORY	923	50	0	4,915		60.00
65.00	06500	RESPIRATORY THERAPY	4,337	1,879	0	879		65.00
66.00	06600	PHYSICAL THERAPY	8,592	0	0	764		66.00
67.00	06700	OCCUPATIONAL THERAPY	3,234	0	0	282		67.00
68.00	06800	SPEECH PATHOLOGY	528	0	0	46		68.00
69.00	06900	ELECTROCARDIOLOGY	1,036	1,996	0	783		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	2,051	0	0	406		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,200	0	0	1,023		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	689		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	242,263	3,970		73.00
74.00	07400	RENAL DIALYSIS	0	0	0	83		74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	2,773	1,083	0	241		76.00
76.01	03190	CHEMOTHERAPY	2,499	6,886	0	586		76.01
76.02	03330	ENDOSCOPY	26	885	0	3		76.02
76.03	03950	WOUND CARE CENTER	767	2,406	0	921		76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	6,741	32,342	0	3,747		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	1,076		95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0		98.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	108,080	296,338	242,263	33,514	0	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	2,974	0	0		192.00
192.01	19201	ASC MOB	0	0	0	0		192.01
192.02	19202	EDUCATION CENTER	0	0	0	0		192.02
192.03	19203	MARKETING	0	0	0	0		192.03
193.00	19300	NONPAID WORKERS	0	0	0	0		193.00
194.00	07950	FOUNDATION	0	0	0	0		194.00
194.01	07951	GIFT SHOP	0	0	0	0		194.01
194.02	07952	CLINIC OF HOPE	654	1,089	0	0		194.02
200.00		Cross Foot Adjustments					18,411	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	108,734	300,401	242,263	33,514	18,411	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0010 | Period: From 07/01/2021 To 06/30/2022 | Worksheet B Part II Date/Time Prepared: 11/28/2022 1:52 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
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
23.00	02300	ALLIED HEALTH RAD TECH PROGRAM				23.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	1,063,834	0	1,063,834	30.00
31.00	03100	INTENSIVE CARE UNIT	325,333	0	325,333	31.00
41.00	04100	SUBPROVIDER - IRF	266,805	0	266,805	41.00
43.00	04300	NURSERY	78,127	0	78,127	43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	1,286,148	0	1,286,148	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	218,093	0	218,093	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,171,665	0	1,171,665	54.00
54.01	03630	ULTRA SOUND	141,369	0	141,369	54.01
56.00	05600	RADIOISOTOPE	657,055	0	657,055	56.00
57.00	05700	CT SCAN	26,128	0	26,128	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	303,340	0	303,340	58.00
59.00	05900	CARDIAC CATHETERIZATION	22,975	0	22,975	59.00
60.00	06000	LABORATORY	269,216	0	269,216	60.00
65.00	06500	RESPIRATORY THERAPY	120,620	0	120,620	65.00
66.00	06600	PHYSICAL THERAPY	209,160	0	209,160	66.00
67.00	06700	OCCUPATIONAL THERAPY	83,161	0	83,161	67.00
68.00	06800	SPEECH PATHOLOGY	20,533	0	20,533	68.00
69.00	06900	ELECTROCARDIOLOGY	205,734	0	205,734	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	80,856	0	80,856	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	184,069	0	184,069	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	77,489	0	77,489	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	579,809	0	579,809	73.00
74.00	07400	RENAL DIALYSIS	7,502	0	7,502	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	104,189	0	104,189	76.00
76.01	03190	CHEMOTHERAPY	665,937	0	665,937	76.01
76.02	03330	ENDOSCOPY	9,753	0	9,753	76.02
76.03	03950	WOUND CARE CENTER	77,722	0	77,722	76.03
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	530,844	0	530,844	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	213,322	0	213,322	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	98.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	9,000,788	0	9,000,788	118.00
		NONREIMBURSABLE COST CENTERS				
192.00	19200	PHYSICIANS' PRIVATE OFFICES	347,651	0	347,651	192.00
192.01	19201	ASC MOB	9,820	0	9,820	192.01
192.02	19202	EDUCATION CENTER	363	0	363	192.02
192.03	19203	MARKETING	0	0	0	192.03
193.00	19300	NONPAID WORKERS	0	0	0	193.00
194.00	07950	FOUNDATION	2,258	0	2,258	194.00
194.01	07951	GIFT SHOP	12,907	0	12,907	194.01
194.02	07952	CLINIC OF HOPE	9,752	0	9,752	194.02
200.00		Cross Foot Adjustments	18,411	0	18,411	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	9,401,950	0	9,401,950	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0010 | Period: From 07/01/2021 To 06/30/2022 | Worksheet B-1 | Date/Time Prepared: 11/28/2022 1:52 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	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	331,432					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		3,307,095				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	12,820	0	38,514,769			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	50,113	32,295	1,684,439	-35,772,167	104,310,904	5.00
7.00	00700	OPERATION OF PLANT	45,990	50,021	0	0	5,018,612	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	518	0	0	0	467,629	8.00
9.00	00900	HOUSEKEEPING	2,015	0	0	0	1,755,043	9.00
10.00	01000	DIETARY	5,205	11,331	0	0	1,415,250	10.00
11.00	01100	CAFETERIA	6,310	9,466	0	0	774,997	11.00
13.00	01300	NURSING ADMINISTRATION	5,461	123,597	1,790,029	0	2,606,968	13.00
15.00	01500	PHARMACY	3,199	6,568	1,624,997	0	7,484,940	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,447	2,144	0	0	25,997	16.00
23.00	02300	ALLIED HEALTH RAD TECH PROGRAM	896	0	194,483	0	263,759	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	29,444	119,270	7,791,193	0	11,697,418	30.00
31.00	03100	INTENSIVE CARE UNIT	5,636	74,917	2,404,640	0	3,758,096	31.00
41.00	04100	SUBPROVIDER - IRF	13,568	462	1,204,799	0	1,719,733	41.00
43.00	04300	NURSERY	1,609	17,682	411,023	0	613,650	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	32,649	495,469	3,198,233	0	7,164,416	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,264	60,634	1,474,175	0	2,170,669	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	23,821	611,285	1,528,563	0	3,443,417	54.00
54.01	03630	ULTRA SOUND	0	97,404	352,164	0	589,106	54.01
56.00	05600	RADIOISOTOPE	2,000	455,104	660,766	0	1,771,709	56.00
57.00	05700	CT SCAN	0	0	653,736	0	868,733	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	222,082	329,147	0	726,203	58.00
59.00	05900	CARDIAC CATHETERIZATION	400	13,087	327	0	28,625	59.00
60.00	06000	LABORATORY	7,900	2,805	167,603	0	6,517,991	60.00
65.00	06500	RESPIRATORY THERAPY	1,237	32,624	1,461,538	0	2,120,040	65.00
66.00	06600	PHYSICAL THERAPY	7,215	17,938	2,386,990	0	3,273,531	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,096	6,740	883,657	0	1,229,001	67.00
68.00	06800	SPEECH PATHOLOGY	1,040	1,101	144,344	0	205,834	68.00
69.00	06900	ELECTROCARDIOLOGY	4,003	106,335	330,015	0	644,127	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	2,728	16,262	549,949	0	872,729	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,309	74,656	207,557	0	1,245,997	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	3,135,688	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	13,585,760	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	287,633	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	4,591	11,560	778,990	0	1,041,766	76.00
76.01	03190	CHEMOTHERAPY	0	448,596	734,815	0	3,318,508	76.01
76.02	03330	ENDOSCOPY	0	6,149	8,565	0	39,422	76.02
76.03	03950	WOUND CARE CENTER	3,000	7,614	200,061	0	1,026,972	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	19,340	96,749	2,459,727	0	4,460,949	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	3,968	64,634	2,069,018	0	3,036,301	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	309,792	3,296,581	37,685,543	-35,772,167	100,407,219	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	20,431	1,986	645,189	0	3,617,478	192.00
192.01	19201	ASC MOB	0	7,675	0	0	1,087	192.01
192.02	19202	EDUCATION CENTER	0	0	0	0	14,824	192.02
192.03	19203	MARKETING	0	0	0	0	0	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	FOUNDATION	180	0	0	0	1,711	194.00
194.01	07951	GIFT SHOP	1,029	0	0	0	9,782	194.01
194.02	07952	CLINIC OF HOPE	0	853	184,037	0	258,803	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	3,150,554	4,219,523	8,037,967		35,772,167	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	9.505884	1.275900	0.208698		0.342938	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			121,865		2,554,776	204.00

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
205.00		Unit cost multiplier (Wkst. B, Part II)			0.003164		0.024492	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: 15-0010 | Period: From 07/01/2021 To 06/30/2022 | Worksheet B-1 | Date/Time Prepared: 11/28/2022 1:52 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (TOTAL PATIENT DAYS)	CAFETERIA (MEALS SERVED)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	222,509					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	518	486,702				8.00
9.00	00900	HOUSEKEEPING	2,015	149,445	195,900			9.00
10.00	01000	DIETARY	5,205	0	0	22,201		10.00
11.00	01100	CAFETERIA	6,310	0	0	0	812,129	11.00
13.00	01300	NURSING ADMINISTRATION	5,461	0	150	0	44,132	13.00
15.00	01500	PHARMACY	3,199	0	0	0	32,423	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,447	0	50	0	0	16.00
23.00	02300	ALLIED HEALTH RAD TECH PROGRAM	896	0	0	0	2,295	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	29,444	155,433	57,000	14,701	193,294	30.00
31.00	03100	INTENSIVE CARE UNIT	5,636	41,440	15,000	2,701	49,377	31.00
41.00	04100	SUBPROVIDER - IRF	13,568	4,071	15,000	3,484	34,456	41.00
43.00	04300	NURSERY	1,609	6,357	7,744	1,315	7,321	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	32,649	4,870	30,000	0	68,221	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,264	17,232	20,756	0	31,970	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	23,821	11,407	3,050	0	40,672	54.00
54.01	03630	ULTRA SOUND	0	3,000	650	0	5,707	54.01
56.00	05600	RADIOISOTOPE	2,000	0	2,250	0	18,344	56.00
57.00	05700	CT SCAN	0	5,460	0	0	12,928	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	1,432	0	0	6,882	58.00
59.00	05900	CARDIAC CATHETERIZATION	400	0	1,000	0	6	59.00
60.00	06000	LABORATORY	7,900	359	6,200	0	6,893	60.00
65.00	06500	RESPIRATORY THERAPY	1,237	330	300	0	32,390	65.00
66.00	06600	PHYSICAL THERAPY	7,215	0	1,000	0	64,170	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,096	0	100	0	24,156	67.00
68.00	06800	SPEECH PATHOLOGY	1,040	305	650	0	3,946	68.00
69.00	06900	ELECTROCARDIOLOGY	4,003	0	400	0	7,735	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	2,728	0	2,550	0	15,316	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,309	7,676	5,600	0	8,965	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	34	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	54	2,250	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	1,000	0	0	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	4,591	2,742	2,000	0	20,710	76.00
76.01	03190	CHEMOTHERAPY	0	0	0	0	18,664	76.01
76.02	03330	ENDOSCOPY	0	0	0	0	195	76.02
76.03	03950	WOUND CARE CENTER	3,000	0	3,200	0	5,725	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	19,340	74,428	18,000	0	50,349	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	3,968	627	0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	200,869	486,702	195,900	22,201	807,242	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	20,431	0	0	0	0	192.00
192.01	19201	ASC MOB	0	0	0	0	0	192.01
192.02	19202	EDUCATION CENTER	0	0	0	0	0	192.02
192.03	19203	MARKETING	0	0	0	0	0	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	FOUNDATION	180	0	0	0	0	194.00
194.01	07951	GIFT SHOP	1,029	0	0	0	0	194.01
194.02	07952	CLINIC OF HOPE	0	0	0	0	4,887	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	6,739,685	643,687	2,615,595	2,058,250	1,231,900	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	30.289494	1.322548	13.351685	92.709788	1.516877	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	623,914	17,829	73,263	113,192	108,734	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	2.803994	0.036632	0.373982	5.098509	0.133888	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00

COST ALLOCATION - STATISTICAL BASIS	Provider CCN: 15-0010	Period: From 07/01/2021 To 06/30/2022	Worksheet B-1 Date/Time Prepared: 11/28/2022 1:52 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (TOTAL PATIENT DAYS)	CAFETERIA (MEALS SERVED)	
			7.00	8.00	9.00	10.00	11.00	
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	ALLIED HEALTH RAD TECH PROGRAM (ASSIGNED TIME)		
			13.00	15.00	16.00	23.00		
		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	576,065					13.00
15.00	01500	PHARMACY	3,261	13,585,760				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	624,586,430			16.00
23.00	02300	ALLIED HEALTH RAD TECH PROGRAM	0	0	0	75,777,792		23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	207,902	0	33,176,788	0		30.00
31.00	03100	INTENSIVE CARE UNIT	62,328	0	13,047,820	0		31.00
41.00	04100	SUBPROVIDER - IRF	47,440	0	7,212,063	0		41.00
43.00	04300	NURSERY	16,244	0	2,686,323	0		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	78,583	0	96,016,297	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	55,701	0	18,595,785	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,058	0	23,082,531	23,082,532		54.00
54.01	03630	ULTRA SOUND	0	0	8,007,118	8,007,118		54.01
56.00	05600	RADIOISOTOPE	3,092	0	25,463,259	25,463,259		56.00
57.00	05700	CT SCAN	0	0	15,782,749	15,782,749		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	3,442,134	3,442,134		58.00
59.00	05900	CARDIAC CATHETERIZATION	525	0	35,245	0		59.00
60.00	06000	LABORATORY	96	0	91,011,418	0		60.00
65.00	06500	RESPIRATORY THERAPY	3,603	0	16,273,127	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	14,142,757	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	5,214,251	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	851,738	0		68.00
69.00	06900	ELECTROCARDIOLOGY	3,827	0	14,501,579	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	7,513,381	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	18,943,163	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	12,762,083	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	13,585,760	73,525,636	0		73.00
74.00	07400	RENAL DIALYSIS	0	0	1,536,731	0		74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	2,076	0	4,467,662	0		76.00
76.01	03190	CHEMOTHERAPY	13,205	0	10,854,575	0		76.01
76.02	03330	ENDOSCOPY	1,698	0	57,538	0		76.02
76.03	03950	WOUND CARE CENTER	4,614	0	17,060,968	0		76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	62,021	0	69,388,096	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	19,933,615	0		95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0		98.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	568,274	13,585,760	624,586,430	75,777,792		118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	5,703	0	0	0		192.00
192.01	19201	ASC MOB	0	0	0	0		192.01
192.02	19202	EDUCATION CENTER	0	0	0	0		192.02
192.03	19203	MARKETING	0	0	0	0		192.03
193.00	19300	NONPAID WORKERS	0	0	0	0		193.00
194.00	07950	FOUNDATION	0	0	0	0		194.00
194.01	07951	GIFT SHOP	0	0	0	0		194.01
194.02	07952	CLINIC OF HOPE	2,088	0	0	0		194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	3,735,353	10,219,033	109,698	384,832		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	6.484256	0.752187	0.000176	0.005078		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	300,401	242,263	33,514	18,411		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.521471	0.017832	0.000054	0.000243		205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0010 | Period: From 07/01/2021 To 06/30/2022 | Worksheet B-1 | Date/Time Prepared: 11/28/2022 1:52 pm

	Cost Center Description	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	ALLIED HEALTH RAD TECH PROGRAM (ASSIGNED TIME)		
		13.00	15.00	16.00	23.00		
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)				0		206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)				0.000000		207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0010 | Period: From 07/01/2021 To 06/30/2022 | Worksheet C Part I Date/Time Prepared: 11/28/2022 1:52 pm

Title XVIII | Hospital | PPS

		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	20,577,424		20,577,424	0	20,577,424	30.00
31.00	03100	INTENSIVE CARE UNIT	6,204,438		6,204,438	0	6,204,438	31.00
41.00	04100	SUBPROVIDER - IRF	3,610,271		3,610,271	0	3,610,271	41.00
43.00	04300	NURSERY	1,223,453		1,223,453	0	1,223,453	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	11,646,985		11,646,985	11,981	11,658,966	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,726,805		3,726,805	0	3,726,805	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,597,946		5,597,946	0	5,597,946	54.00
54.01	03630	ULTRA SOUND	854,506		854,506	0	854,506	54.01
56.00	05600	RADIOISOTOPE	2,651,607		2,651,607	0	2,651,607	56.00
57.00	05700	CT SCAN	1,276,409		1,276,409	0	1,276,409	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,005,664		1,005,664	0	1,005,664	58.00
59.00	05900	CARDIAC CATHETERIZATION	67,329		67,329	0	67,329	59.00
60.00	06000	LABORATORY	9,102,896		9,102,896	60,482	9,163,378	60.00
65.00	06500	RESPIRATORY THERAPY	2,964,351	0	2,964,351	0	2,964,351	65.00
66.00	06600	PHYSICAL THERAPY	4,727,867	0	4,727,867	0	4,727,867	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,783,143	0	1,783,143	0	1,783,143	67.00
68.00	06800	SPEECH PATHOLOGY	323,141	0	323,141	0	323,141	68.00
69.00	06900	ELECTROCARDIOLOGY	1,030,713		1,030,713	0	1,030,713	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,313,252		1,313,252	0	1,313,252	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,905,668		1,905,668	0	1,905,668	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,213,326		4,213,326	0	4,213,326	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	28,506,912		28,506,912	0	28,506,912	73.00
74.00	07400	RENAL DIALYSIS	399,895		399,895	0	399,895	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1,614,077		1,614,077	0	1,614,077	76.00
76.01	03190	CHEMOTHERAPY	4,572,396		4,572,396	0	4,572,396	76.01
76.02	03330	ENDOSCOPY	64,257		64,257	0	64,257	76.02
76.03	03950	WOUND CARE CENTER	1,554,358		1,554,358	0	1,554,358	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	7,406,087		7,406,087	0	7,406,087	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,193,297		1,193,297		1,193,297	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	4,202,090		4,202,090	0	4,202,090	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0		0	0	0	98.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	135,320,563	0	135,320,563	72,463	135,393,026	200.00
201.00		Less Observation Beds	1,193,297		1,193,297		1,193,297	201.00
202.00		Total (see instructions)	134,127,266	0	134,127,266	72,463	134,199,729	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0010 | Period: From 07/01/2021 To 06/30/2022 | Worksheet C Part I | Date/Time Prepared: 11/28/2022 1:52 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Charges Inpatient	Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	30,768,844		30,768,844			30.00
31.00	03100	INTENSIVE CARE UNIT	13,047,820		13,047,820			31.00
41.00	04100	SUBPROVIDER - IRF	7,212,063		7,212,063			41.00
43.00	04300	NURSERY	2,686,323		2,686,323			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	25,331,287	70,685,010	96,016,297	0.121302	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	17,482,366	1,113,419	18,595,785	0.200411	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,737,803	20,344,728	23,082,531	0.242519	0.000000	54.00
54.01	03630	ULTRA SOUND	1,937,877	6,069,241	8,007,118	0.106718	0.000000	54.01
56.00	05600	RADIOISOTOPE	120,790	25,342,469	25,463,259	0.104135	0.000000	56.00
57.00	05700	CT SCAN	4,215,168	11,567,581	15,782,749	0.080874	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	726,099	2,716,035	3,442,134	0.292163	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	35,245	0	35,245	1.910314	0.000000	59.00
60.00	06000	LABORATORY	36,321,959	54,689,459	91,011,418	0.100019	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	10,563,632	5,709,495	16,273,127	0.182162	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	4,120,668	10,022,089	14,142,757	0.334296	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,390,188	1,824,063	5,214,251	0.341975	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	620,462	231,276	851,738	0.379390	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	2,920,978	11,580,601	14,501,579	0.071076	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	437,204	7,076,177	7,513,381	0.174788	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	9,212,303	9,730,860	18,943,163	0.100599	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,286,459	6,475,624	12,762,083	0.330144	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	24,391,016	49,134,620	73,525,636	0.387714	0.000000	73.00
74.00	07400	RENAL DIALYSIS	1,475,196	61,535	1,536,731	0.260224	0.000000	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	4,467,662	4,467,662	0.361280	0.000000	76.00
76.01	03190	CHEMOTHERAPY	314,210	10,540,365	10,854,575	0.421241	0.000000	76.01
76.02	03330	ENDOSCOPY	38,032	19,506	57,538	1.116775	0.000000	76.02
76.03	03950	WOUND CARE CENTER	89,403	16,971,565	17,060,968	0.091106	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	17,138,306	52,249,790	69,388,096	0.106734	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	386,295	2,021,649	2,407,944	0.495567	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	3,788	19,929,827	19,933,615	0.210804	0.000000	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0.000000	0.000000	98.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	224,011,784	400,574,646	624,586,430			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	224,011,784	400,574,646	624,586,430			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0010 | Period: From 07/01/2021 To 06/30/2022 | Worksheet C Part I Date/Time Prepared: 11/28/2022 1:52 pm

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		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
41.00	04100	SUBPROVIDER - IRF		41.00
43.00	04300	NURSERY		43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.121427	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.200411	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.242519	54.00
54.01	03630	ULTRA SOUND	0.106718	54.01
56.00	05600	RADIOISOTOPE	0.104135	56.00
57.00	05700	CT SCAN	0.080874	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.292163	58.00
59.00	05900	CARDIAC CATHETERIZATION	1.910314	59.00
60.00	06000	LABORATORY	0.100684	60.00
65.00	06500	RESPIRATORY THERAPY	0.182162	65.00
66.00	06600	PHYSICAL THERAPY	0.334296	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.341975	67.00
68.00	06800	SPEECH PATHOLOGY	0.379390	68.00
69.00	06900	ELECTROCARDIOLOGY	0.071076	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.174788	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.100599	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.330144	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.387714	73.00
74.00	07400	RENAL DIALYSIS	0.260224	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.361280	76.00
76.01	03190	CHEMOTHERAPY	0.421241	76.01
76.02	03330	ENDOSCOPY	1.116775	76.02
76.03	03950	WOUND CARE CENTER	0.091106	76.03
		OUTPATIENT SERVICE COST CENTERS		
91.00	09100	EMERGENCY	0.106734	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.495567	92.00
		OTHER REIMBURSABLE COST CENTERS		
95.00	09500	AMBULANCE SERVICES	0.210804	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0.000000	98.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0010 | Period: From 07/01/2021 To 06/30/2022 | Worksheet C Part I Date/Time Prepared: 11/28/2022 1:52 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Disallowance	Total Costs	
						Costs		
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	20,577,424		20,577,424	0	20,577,424	30.00
31.00	03100	INTENSIVE CARE UNIT	6,204,438		6,204,438	0	6,204,438	31.00
41.00	04100	SUBPROVIDER - IRF	3,610,271		3,610,271	0	3,610,271	41.00
43.00	04300	NURSERY	1,223,453		1,223,453	0	1,223,453	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	11,646,985		11,646,985	11,981	11,658,966	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,726,805		3,726,805	0	3,726,805	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,597,946		5,597,946	0	5,597,946	54.00
54.01	03630	ULTRA SOUND	854,506		854,506	0	854,506	54.01
56.00	05600	RADIOISOTOPE	2,651,607		2,651,607	0	2,651,607	56.00
57.00	05700	CT SCAN	1,276,409		1,276,409	0	1,276,409	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,005,664		1,005,664	0	1,005,664	58.00
59.00	05900	CARDIAC CATHETERIZATION	67,329		67,329	0	67,329	59.00
60.00	06000	LABORATORY	9,102,896		9,102,896	60,482	9,163,378	60.00
65.00	06500	RESPIRATORY THERAPY	2,964,351	0	2,964,351	0	2,964,351	65.00
66.00	06600	PHYSICAL THERAPY	4,727,867	0	4,727,867	0	4,727,867	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,783,143	0	1,783,143	0	1,783,143	67.00
68.00	06800	SPEECH PATHOLOGY	323,141	0	323,141	0	323,141	68.00
69.00	06900	ELECTROCARDIOLOGY	1,030,713		1,030,713	0	1,030,713	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,313,252		1,313,252	0	1,313,252	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,905,668		1,905,668	0	1,905,668	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,213,326		4,213,326	0	4,213,326	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	28,506,912		28,506,912	0	28,506,912	73.00
74.00	07400	RENAL DIALYSIS	399,895		399,895	0	399,895	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1,614,077		1,614,077	0	1,614,077	76.00
76.01	03190	CHEMOTHERAPY	4,572,396		4,572,396	0	4,572,396	76.01
76.02	03330	ENDOSCOPY	64,257		64,257	0	64,257	76.02
76.03	03950	WOUND CARE CENTER	1,554,358		1,554,358	0	1,554,358	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	7,406,087		7,406,087	0	7,406,087	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,193,297		1,193,297		1,193,297	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	4,202,090		4,202,090	0	4,202,090	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0		0	0	0	98.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	135,320,563	0	135,320,563	72,463	135,393,026	200.00
201.00		Less Observation Beds	1,193,297		1,193,297		1,193,297	201.00
202.00		Total (see instructions)	134,127,266	0	134,127,266	72,463	134,199,729	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0010 | Period: From 07/01/2021 To 06/30/2022 | Worksheet C Part I Date/Time Prepared: 11/28/2022 1:52 pm

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	30,768,844		30,768,844			30.00
31.00	03100	INTENSIVE CARE UNIT	13,047,820		13,047,820			31.00
41.00	04100	SUBPROVIDER - IRF	7,212,063		7,212,063			41.00
43.00	04300	NURSERY	2,686,323		2,686,323			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	25,331,287	70,685,010	96,016,297	0.121302	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	17,482,366	1,113,419	18,595,785	0.200411	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,737,803	20,344,728	23,082,531	0.242519	0.000000	54.00
54.01	03630	ULTRA SOUND	1,937,877	6,069,241	8,007,118	0.106718	0.000000	54.01
56.00	05600	RADIOISOTOPE	120,790	25,342,469	25,463,259	0.104135	0.000000	56.00
57.00	05700	CT SCAN	4,215,168	11,567,581	15,782,749	0.080874	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	726,099	2,716,035	3,442,134	0.292163	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	35,245	0	35,245	1.910314	0.000000	59.00
60.00	06000	LABORATORY	36,321,959	54,689,459	91,011,418	0.100019	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	10,563,632	5,709,495	16,273,127	0.182162	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	4,120,668	10,022,089	14,142,757	0.334296	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,390,188	1,824,063	5,214,251	0.341975	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	620,462	231,276	851,738	0.379390	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	2,920,978	11,580,601	14,501,579	0.071076	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	437,204	7,076,177	7,513,381	0.174788	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	9,212,303	9,730,860	18,943,163	0.100599	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,286,459	6,475,624	12,762,083	0.330144	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	24,391,016	49,134,620	73,525,636	0.387714	0.000000	73.00
74.00	07400	RENAL DIALYSIS	1,475,196	61,535	1,536,731	0.260224	0.000000	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	4,467,662	4,467,662	0.361280	0.000000	76.00
76.01	03190	CHEMOTHERAPY	314,210	10,540,365	10,854,575	0.421241	0.000000	76.01
76.02	03330	ENDOSCOPY	38,032	19,506	57,538	1.116775	0.000000	76.02
76.03	03950	WOUND CARE CENTER	89,403	16,971,565	17,060,968	0.091106	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	17,138,306	52,249,790	69,388,096	0.106734	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	386,295	2,021,649	2,407,944	0.495567	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	3,788	19,929,827	19,933,615	0.210804	0.000000	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0.000000	0.000000	98.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	224,011,784	400,574,646	624,586,430			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	224,011,784	400,574,646	624,586,430			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0010 | Period: From 07/01/2021 To 06/30/2022 | Worksheet C Part I | Date/Time Prepared: 11/28/2022 1:52 pm

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
41.00	04100	SUBPROVIDER - IRF		41.00
43.00	04300	NURSERY		43.00
		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
54.01	03630	ULTRA SOUND	0.000000	54.01
56.00	05600	RADIOISOTOPE	0.000000	56.00
57.00	05700	CT SCAN	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	59.00
60.00	06000	LABORATORY	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0.000000	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	76.00
76.01	03190	CHEMOTHERAPY	0.000000	76.01
76.02	03330	ENDOSCOPY	0.000000	76.02
76.03	03950	WOUND CARE CENTER	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS		
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS		
95.00	09500	AMBULANCE SERVICES	0.000000	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0.000000	98.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-0010 | Period: From 07/01/2021 To 06/30/2022 | Worksheet D Part I | Date/Time Prepared: 11/28/2022 1:52 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,063,834	0	1,063,834	15,606	68.17	30.00
31.00	INTENSIVE CARE UNIT	325,333		325,333	2,701	120.45	31.00
41.00	SUBPROVIDER - IRF	266,805	0	266,805	3,484	76.58	41.00
43.00	NURSERY	78,127		78,127	1,315	59.41	43.00
200.00	Total (lines 30 through 199)	1,734,099		1,734,099	23,106		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	
		6.00	7.00	
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	4,925	335,737	30.00
31.00	INTENSIVE CARE UNIT	754	90,819	31.00
41.00	SUBPROVIDER - IRF	1,945	148,948	41.00
43.00	NURSERY	0	0	43.00
200.00	Total (lines 30 through 199)	7,624	575,504	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-0010 | Period: From 07/01/2021 To 06/30/2022 | Worksheet D Part II Date/Time Prepared: 11/28/2022 1:52 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,286,148	96,016,297	0.013395	9,944,345	133,205	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	218,093	18,595,785	0.011728	112,269	1,317	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,171,665	23,082,531	0.050760	941,283	47,780	54.00
54.01	03630	ULTRA SOUND	141,369	8,007,118	0.017655	576,772	10,183	54.01
56.00	05600	RADIOISOTOPE	657,055	25,463,259	0.025804	37,468	967	56.00
57.00	05700	CT SCAN	26,128	15,782,749	0.001655	1,534,682	2,540	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	303,340	3,442,134	0.088126	224,200	19,758	58.00
59.00	05900	CARDIAC CATHETERIZATION	22,975	35,245	0.651866	30,928	20,161	59.00
60.00	06000	LABORATORY	269,216	91,011,418	0.002958	11,367,622	33,625	60.00
65.00	06500	RESPIRATORY THERAPY	120,620	16,273,127	0.007412	2,406,173	17,835	65.00
66.00	06600	PHYSICAL THERAPY	209,160	14,142,757	0.014789	914,881	13,530	66.00
67.00	06700	OCCUPATIONAL THERAPY	83,161	5,214,251	0.015949	760,207	12,125	67.00
68.00	06800	SPEECH PATHOLOGY	20,533	851,738	0.024107	175,446	4,229	68.00
69.00	06900	ELECTROCARDIOLOGY	205,734	14,501,579	0.014187	1,795,626	25,475	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	80,856	7,513,381	0.010762	213,306	2,296	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	184,069	18,943,163	0.009717	2,924,149	28,414	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	77,489	12,762,083	0.006072	2,753,986	16,722	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	579,809	73,525,636	0.007886	6,959,375	54,882	73.00
74.00	07400	RENAL DIALYSIS	7,502	1,536,731	0.004882	436,153	2,129	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	104,189	4,467,662	0.023321	0	0	76.00
76.01	03190	CHEMOTHERAPY	665,937	10,854,575	0.061351	6,058	372	76.01
76.02	03330	ENDOSCOPY	9,753	57,538	0.169505	21,993	3,728	76.02
76.03	03950	WOUND CARE CENTER	77,722	17,060,968	0.004556	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	530,844	69,388,096	0.007650	5,809,832	44,445	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	61,692	2,407,944	0.025620	109,907	2,816	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0.000000	0	0	98.00
200.00		Total (lines 50 through 199)	7,115,059	550,937,765		50,056,661	498,534	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0010 | Period: From 07/01/2021 To 06/30/2022 | Worksheet D Part III Date/Time Prepared: 11/28/2022 1:52 pm

Title XVIII | Hospital | PPS

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

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	15,606	0.00	4,925	30.00
31.00	03100	INTENSIVE CARE UNIT		0	2,701	0.00	754	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	3,484	0.00	1,945	41.00
43.00	04300	NURSERY		0	1,315	0.00	0	43.00
200.00		Total (lines 30 through 199)		0	23,106		7,624	200.00

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

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0010

Period: From 07/01/2021 To 06/30/2022

Worksheet D Part IV

Date/Time Prepared: 11/28/2022 1:52 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	117,213	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	40,660	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	129,335	56.00
57.00	05700	CT SCAN	0	0	0	0	80,145	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	17,479	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.00
76.01	03190	CHEMOTHERAPY	0	0	0	0	0	76.01
76.02	03330	ENDOSCOPY	0	0	0	0	0	76.02
76.03	03950	WOUND CARE CENTER	0	0	0	0	0	76.03
		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
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
200.00		Total (lines 50 through 199)	0	0	0	0	384,832	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0010 | Period: From 07/01/2021 To 06/30/2022 | Worksheet D Part IV | Date/Time Prepared: 11/28/2022 1:52 pm

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		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	96,016,297	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	18,595,785	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	117,213	117,213	23,082,531	0.005078	54.00
54.01	03630	ULTRA SOUND	0	40,660	40,660	8,007,118	0.005078	54.01
56.00	05600	RADIOISOTOPE	0	129,335	129,335	25,463,259	0.005079	56.00
57.00	05700	CT SCAN	0	80,145	80,145	15,782,749	0.005078	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	17,479	17,479	3,442,134	0.005078	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	35,245	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	91,011,418	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	16,273,127	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	14,142,757	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	5,214,251	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	851,738	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	14,501,579	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	7,513,381	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	18,943,163	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	12,762,083	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	73,525,636	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	1,536,731	0.000000	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	4,467,662	0.000000	76.00
76.01	03190	CHEMOTHERAPY	0	0	0	10,854,575	0.000000	76.01
76.02	03330	ENDOSCOPY	0	0	0	57,538	0.000000	76.02
76.03	03950	WOUND CARE CENTER	0	0	0	17,060,968	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	69,388,096	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	2,407,944	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0.000000	98.00
200.00		Total (lines 50 through 199)	0	384,832	384,832	550,937,765		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0010 | Period: From 07/01/2021 To 06/30/2022 | Worksheet D Part IV | Date/Time Prepared: 11/28/2022 1:52 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	9,944,345	0	18,624,980	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	112,269	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.005078	941,283	4,780	3,800,162	19,297	54.00
54.01	03630	ULTRA SOUND	0.005078	576,772	2,929	1,174,109	5,962	54.01
56.00	05600	RADIOISOTOPE	0.005079	37,468	190	8,545,560	43,403	56.00
57.00	05700	CT SCAN	0.005078	1,534,682	7,793	2,691,643	13,668	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.005078	224,200	1,138	657,206	3,337	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	30,928	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	11,367,622	0	6,521,274	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	2,406,173	0	132,165	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	914,881	0	40,930	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	760,207	0	16,762	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	175,446	0	9,096	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	1,795,626	0	5,070,255	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	213,306	0	147,773	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	2,924,149	0	1,982,511	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	2,753,986	0	2,465,670	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	6,959,375	0	17,789,666	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	436,153	0	0	0	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	0	0	6,300	0	76.00
76.01	03190	CHEMOTHERAPY	0.000000	6,058	0	3,801,013	0	76.01
76.02	03330	ENDOSCOPY	0.000000	21,993	0	5,256	0	76.02
76.03	03950	WOUND CARE CENTER	0.000000	0	0	4,937,421	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.000000	5,809,832	0	9,484,078	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	109,907	0	1,674,893	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	0	0	98.00
200.00		Total (lines 50 through 199)		50,056,661	16,830	89,578,723	85,667	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0010 | Period: From 07/01/2021 To 06/30/2022 | Worksheet D Part V | Date/Time Prepared: 11/28/2022 1:52 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.121302	18,624,980	0	0	2,259,247	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.200411	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.242519	3,800,162	0	0	921,611	54.00
54.01	03630	ULTRA SOUND	0.106718	1,174,109	0	0	125,299	54.01
56.00	05600	RADIOISOTOPE	0.104135	8,545,560	0	0	889,892	56.00
57.00	05700	CT SCAN	0.080874	2,691,643	0	0	217,684	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.292163	657,206	0	0	192,011	58.00
59.00	05900	CARDIAC CATHETERIZATION	1.910314	0	0	0	0	59.00
60.00	06000	LABORATORY	0.100019	6,521,274	0	0	652,251	60.00
65.00	06500	RESPIRATORY THERAPY	0.182162	132,165	0	0	24,075	65.00
66.00	06600	PHYSICAL THERAPY	0.334296	40,930	0	0	13,683	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.341975	16,762	0	0	5,732	67.00
68.00	06800	SPEECH PATHOLOGY	0.379390	9,096	0	0	3,451	68.00
69.00	06900	ELECTROCARDIOLOGY	0.071076	5,070,255	0	0	360,373	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.174788	147,773	0	0	25,829	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.100599	1,982,511	0	0	199,439	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.330144	2,465,670	0	0	814,026	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.387714	17,789,666	0	5,306	6,897,303	73.00
74.00	07400	RENAL DIALYSIS	0.260224	0	0	0	0	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.361280	6,300	0	0	2,276	76.00
76.01	03190	CHEMOTHERAPY	0.421241	3,801,013	0	0	1,601,143	76.01
76.02	03330	ENDOSCOPY	1.116775	5,256	0	0	5,870	76.02
76.03	03950	WOUND CARE CENTER	0.091106	4,937,421	0	0	449,829	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.106734	9,484,078	0	0	1,012,274	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.495567	1,674,893	0	0	830,022	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.210804		0			95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	0	0	98.00
200.00		Subtotal (see instructions)		89,578,723	0	5,306	17,503,320	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		89,578,723	0	5,306	17,503,320	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0010 | Period: From 07/01/2021 To 06/30/2022 | Worksheet D Part V Date/Time Prepared: 11/28/2022 1:52 pm

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		Cost Center Description	Costs		
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	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
54.01	03630	ULTRA SOUND	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	56.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,057	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	76.00
76.01	03190	CHEMOTHERAPY	0	0	76.01
76.02	03330	ENDOSCOPY	0	0	76.02
76.03	03950	WOUND CARE CENTER	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0		95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	98.00
200.00		Subtotal (see instructions)	0	2,057	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	0	2,057	202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 15-0010
Component CCN: 15-T010

Period: From 07/01/2021 To 06/30/2022

Worksheet D Part II
Date/Time Prepared: 11/28/2022 1:52 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,286,148	96,016,297	0.013395	15,010	201	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	218,093	18,595,785	0.011728	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,171,665	23,082,531	0.050760	64,600	3,279	54.00
54.01	03630	ULTRA SOUND	141,369	8,007,118	0.017655	18,066	319	54.01
56.00	05600	RADIOISOTOPE	657,055	25,463,259	0.025804	0	0	56.00
57.00	05700	CT SCAN	26,128	15,782,749	0.001655	30,600	51	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	303,340	3,442,134	0.088126	12,350	1,088	58.00
59.00	05900	CARDIAC CATHETERIZATION	22,975	35,245	0.651866	0	0	59.00
60.00	06000	LABORATORY	269,216	91,011,418	0.002958	1,029,660	3,046	60.00
65.00	06500	RESPIRATORY THERAPY	120,620	16,273,127	0.007412	123,823	918	65.00
66.00	06600	PHYSICAL THERAPY	209,160	14,142,757	0.014789	948,748	14,031	66.00
67.00	06700	OCCUPATIONAL THERAPY	83,161	5,214,251	0.015949	856,847	13,666	67.00
68.00	06800	SPEECH PATHOLOGY	20,533	851,738	0.024107	123,543	2,978	68.00
69.00	06900	ELECTROCARDIOLOGY	205,734	14,501,579	0.014187	46,522	660	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	80,856	7,513,381	0.010762	5,360	58	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	184,069	18,943,163	0.009717	169,364	1,646	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	77,489	12,762,083	0.006072	5,262	32	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	579,809	73,525,636	0.007886	404,876	3,193	73.00
74.00	07400	RENAL DIALYSIS	7,502	1,536,731	0.004882	125,572	613	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	104,189	4,467,662	0.023321	0	0	76.00
76.01	03190	CHEMOTHERAPY	665,937	10,854,575	0.061351	0	0	76.01
76.02	03330	ENDOSCOPY	9,753	57,538	0.169505	0	0	76.02
76.03	03950	WOUND CARE CENTER	77,722	17,060,968	0.004556	131	1	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	530,844	69,388,096	0.007650	7,816	60	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	2,407,944	0.000000	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0.000000	0	0	98.00
200.00		Total (lines 50 through 199)	7,053,367	550,937,765		3,988,150	45,840	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0010 | Component CCN: 15-T010 | Period: From 07/01/2021 To 06/30/2022 | Worksheet D Part IV | Date/Time Prepared: 11/28/2022 1:52 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	117,213	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	40,660	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	129,335	56.00
57.00	05700	CT SCAN	0	0	0	0	80,145	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	17,479	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.00
76.01	03190	CHEMOTHERAPY	0	0	0	0	0	76.01
76.02	03330	ENDOSCOPY	0	0	0	0	0	76.02
76.03	03950	WOUND CARE CENTER	0	0	0	0	0	76.03
		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
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
200.00		Total (lines 50 through 199)	0	0	0	0	384,832	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0010 | Component CCN: 15-T010 | Period: From 07/01/2021 To 06/30/2022 | Worksheet D Part IV | Date/Time Prepared: 11/28/2022 1:52 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	96,016,297	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	18,595,785	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	117,213	117,213	23,082,531	0.005078	54.00
54.01	03630	ULTRA SOUND	0	40,660	40,660	8,007,118	0.005078	54.01
56.00	05600	RADIOISOTOPE	0	129,335	129,335	25,463,259	0.005079	56.00
57.00	05700	CT SCAN	0	80,145	80,145	15,782,749	0.005078	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	17,479	17,479	3,442,134	0.005078	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	35,245	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	91,011,418	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	16,273,127	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	14,142,757	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	5,214,251	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	851,738	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	14,501,579	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	7,513,381	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	18,943,163	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	12,762,083	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	73,525,636	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	1,536,731	0.000000	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	4,467,662	0.000000	76.00
76.01	03190	CHEMOTHERAPY	0	0	0	10,854,575	0.000000	76.01
76.02	03330	ENDOSCOPY	0	0	0	57,538	0.000000	76.02
76.03	03950	WOUND CARE CENTER	0	0	0	17,060,968	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	69,388,096	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	2,407,944	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0.000000	98.00
200.00		Total (lines 50 through 199)	0	384,832	384,832	550,937,765		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0010 | Component CCN: 15-T010 | Period: From 07/01/2021 To 06/30/2022 | Worksheet D Part IV | Date/Time Prepared: 11/28/2022 1:52 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	15,010	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.005078	64,600	328	0	0	54.00
54.01	03630	ULTRA SOUND	0.005078	18,066	92	0	0	54.01
56.00	05600	RADIOISOTOPE	0.005079	0	0	0	0	56.00
57.00	05700	CT SCAN	0.005078	30,600	155	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.005078	12,350	63	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	1,029,660	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	123,823	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	948,748	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	856,847	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	123,543	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	46,522	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	5,360	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	169,364	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	5,262	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	404,876	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	125,572	0	0	0	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	0	0	0	0	76.00
76.01	03190	CHEMOTHERAPY	0.000000	0	0	0	0	76.01
76.02	03330	ENDOSCOPY	0.000000	0	0	0	0	76.02
76.03	03950	WOUND CARE CENTER	0.000000	131	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.000000	7,816	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	0	0	98.00
200.00		Total (lines 50 through 199)		3,988,150	638	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0010	Period: From 07/01/2021 To 06/30/2022	Worksheet D-1 Date/Time Prepared: 11/28/2022 1:52 pm
	Title XVIII	Hospital	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	15,606	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	15,606	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)	14,701	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	4,925	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	20,577,424	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	20,577,424	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)	20,577,424	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,318.56	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	6,493,908	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)	6,493,908	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0010 | Period: From 07/01/2021 To 06/30/2022 | Worksheet D-1 | Date/Time Prepared: 11/28/2022 1:52 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	6,204,438	2,701	2,297.09	754	1,732,006	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)	8,869,389	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	17,095,303	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)	426,556	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	515,364	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	941,920	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	16,153,383	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)	905	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,318.56	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,193,297	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0010 | Period: From 07/01/2021 To 06/30/2022 | Worksheet D-1 | Date/Time Prepared: 11/28/2022 1:52 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	1,063,834	20,577,424	0.051699	1,193,297	61,692	90.00
91.00	Nursing Program cost	0	20,577,424	0.000000	1,193,297	0	91.00
92.00	Allied health cost	0	20,577,424	0.000000	1,193,297	0	92.00
93.00	All other Medical Education	0	20,577,424	0.000000	1,193,297	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0010 Component CCN: 15-T010	Period: From 07/01/2021 To 06/30/2022	Worksheet D-1 Date/Time Prepared: 11/28/2022 1:52 pm
	Title XVIII	Subprovider - IRF	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,484	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,484	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	3,484	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	1,945	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	3,610,271	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,610,271	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)	3,610,271	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,036.24	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,015,487	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	2,015,487	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0010 | Period: From 07/01/2021 To 06/30/2022 | Worksheet D-1

Component CCN: 15-T010 | Date/Time Prepared: 11/28/2022 1:52 pm

Title XVIII | Subprovider - IRF | PPS

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	1,022,299	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	3,037,786	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)	148,948	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	46,478	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	195,426	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	2,842,360	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)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0010 Component CCN: 15-T010	Period: From 07/01/2021 To 06/30/2022	Worksheet D-1 Date/Time Prepared: 11/28/2022 1:52 pm
	Title XVIII	Subprovider - IRF	PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	266,805	3,610,271	0.073902	0	0	90.00
91.00	Nursing Program cost	0	3,610,271	0.000000	0	0	91.00
92.00	Allied health cost	0	3,610,271	0.000000	0	0	92.00
93.00	All other Medical Education	0	3,610,271	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0010 | Period: From 07/01/2021 To 06/30/2022 | Worksheet D-1 | Date/Time Prepared: 11/28/2022 1:52 pm

Title XIX | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	15,606	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	15,606	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)	14,701	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	231	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	1,315	15.00
16.00	Nursery days (title V or XIX only)	88	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	20,577,424	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	20,577,424	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)	20,577,424	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,318.56	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	304,587	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)	304,587	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0010 | Period: From 07/01/2021 To 06/30/2022 | Worksheet D-1 | Date/Time Prepared: 11/28/2022 1:52 pm

Title XIX | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	1,223,453	1,315	930.38	88	81,873	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	6,204,438	2,701	2,297.09	190	436,447	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)	770,536	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	1,593,443	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)	905	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,318.56	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,193,297	89.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0010	Period: From 07/01/2021 To 06/30/2022	Worksheet D-1 Date/Time Prepared: 11/28/2022 1:52 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	1,063,834	20,577,424	0.051699	1,193,297	61,692	90.00
91.00	Nursing Program cost	0	20,577,424	0.000000	1,193,297	0	91.00
92.00	Allied health cost	0	20,577,424	0.000000	1,193,297	0	92.00
93.00	All other Medical Education	0	20,577,424	0.000000	1,193,297	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0010 Component CCN: 15-T010	Period: From 07/01/2021 To 06/30/2022	Worksheet D-1 Date/Time Prepared: 11/28/2022 1:52 pm
	Title XIX	Subprovider - IRF	Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,484	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,484	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	3,484	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	14	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	1,315	15.00
16.00	Nursery days (title V or XIX only)	88	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	3,610,271	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,610,271	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)	3,610,271	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,036.24	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	14,507	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)	14,507	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0010 | Component CCN: 15-T010 | Period: From 07/01/2021 To 06/30/2022 | Worksheet D-1 | Date/Time Prepared: 11/28/2022 1:52 pm

Title XIX | Subprovider - IRF | Cost

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	14,226	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	28,733	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)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0010 | Component CCN: 15-T010 | Period: From 07/01/2021 To 06/30/2022 | Worksheet D-1 | Date/Time Prepared: 11/28/2022 1:52 pm

Title XIX | Subprovider - IRF | 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	266,805	3,610,271	0.073902	0	0	90.00
91.00	Nursing Program cost	0	3,610,271	0.000000	0	0	91.00
92.00	Allied health cost	0	3,610,271	0.000000	0	0	92.00
93.00	All other Medical Education	0	3,610,271	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0010 | Period: From 07/01/2021 To 06/30/2022 | Worksheet D-3 | Date/Time Prepared: 11/28/2022 1:52 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		10,378,364		30.00
31.00	03100	INTENSIVE CARE UNIT		3,664,382		31.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.121427	9,944,345	1,207,512	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.200411	112,269	22,500	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.242519	941,283	228,279	54.00
54.01	03630	ULTRA SOUND	0.106718	576,772	61,552	54.01
56.00	05600	RADIOISOTOPE	0.104135	37,468	3,902	56.00
57.00	05700	CT SCAN	0.080874	1,534,682	124,116	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.292163	224,200	65,503	58.00
59.00	05900	CARDIAC CATHETERIZATION	1.910314	30,928	59,082	59.00
60.00	06000	LABORATORY	0.100684	11,367,622	1,144,538	60.00
65.00	06500	RESPIRATORY THERAPY	0.182162	2,406,173	438,313	65.00
66.00	06600	PHYSICAL THERAPY	0.334296	914,881	305,841	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.341975	760,207	259,972	67.00
68.00	06800	SPEECH PATHOLOGY	0.379390	175,446	66,562	68.00
69.00	06900	ELECTROCARDIOLOGY	0.071076	1,795,626	127,626	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.174788	213,306	37,283	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.100599	2,924,149	294,166	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.330144	2,753,986	909,212	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.387714	6,959,375	2,698,247	73.00
74.00	07400	RENAL DIALYSIS	0.260224	436,153	113,497	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.361280	0	0	76.00
76.01	03190	CHEMOTHERAPY	0.421241	6,058	2,552	76.01
76.02	03330	ENDOSCOPY	1.116775	21,993	24,561	76.02
76.03	03950	WOUND CARE CENTER	0.091106	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.106734	5,809,832	620,107	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.495567	109,907	54,466	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	98.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		50,056,661	8,869,389	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)		50,056,661		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0010 | Component CCN: 15-T010 | Period: From 07/01/2021 To 06/30/2022 | Worksheet D-3 | Date/Time Prepared: 11/28/2022 1:52 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
41.00	04100	SUBPROVIDER - IRF		4,088,788		41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.121427	15,010	1,823	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.200411	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.242519	64,600	15,667	54.00
54.01	03630	ULTRA SOUND	0.106718	18,066	1,928	54.01
56.00	05600	RADIOISOTOPE	0.104135	0	0	56.00
57.00	05700	CT SCAN	0.080874	30,600	2,475	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.292163	12,350	3,608	58.00
59.00	05900	CARDIAC CATHETERIZATION	1.910314	0	0	59.00
60.00	06000	LABORATORY	0.100684	1,029,660	103,670	60.00
65.00	06500	RESPIRATORY THERAPY	0.182162	123,823	22,556	65.00
66.00	06600	PHYSICAL THERAPY	0.334296	948,748	317,163	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.341975	856,847	293,020	67.00
68.00	06800	SPEECH PATHOLOGY	0.379390	123,543	46,871	68.00
69.00	06900	ELECTROCARDIOLOGY	0.071076	46,522	3,307	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.174788	5,360	937	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.100599	169,364	17,038	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.330144	5,262	1,737	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.387714	404,876	156,976	73.00
74.00	07400	RENAL DIALYSIS	0.260224	125,572	32,677	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.361280	0	0	76.00
76.01	03190	CHEMOTHERAPY	0.421241	0	0	76.01
76.02	03330	ENDOSCOPY	1.116775	0	0	76.02
76.03	03950	WOUND CARE CENTER	0.091106	131	12	76.03
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.106734	7,816	834	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.495567	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	98.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		3,988,150	1,022,299	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)		3,988,150		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0010 | Period: From 07/01/2021 To 06/30/2022 | Worksheet D-3 | Date/Time Prepared: 11/28/2022 1:52 pm

Title XIX | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		574,154		30.00
31.00	03100	INTENSIVE CARE UNIT		370,266		31.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
43.00	04300	NURSERY		191,636		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.121302	928,863	112,673	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.200411	501,668	100,540	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.242519	78,098	18,940	54.00
54.01	03630	ULTRA SOUND	0.106718	53,441	5,703	54.01
56.00	05600	RADIOISOTOPE	0.104135	0	0	56.00
57.00	05700	CT SCAN	0.080874	128,808	10,417	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.292163	19,843	5,797	58.00
59.00	05900	CARDIAC CATHETERIZATION	1.910314	0	0	59.00
60.00	06000	LABORATORY	0.100019	1,039,837	104,003	60.00
65.00	06500	RESPIRATORY THERAPY	0.182162	245,923	44,798	65.00
66.00	06600	PHYSICAL THERAPY	0.334296	45,472	15,201	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.341975	10,501	3,591	67.00
68.00	06800	SPEECH PATHOLOGY	0.379390	54	20	68.00
69.00	06900	ELECTROCARDIOLOGY	0.071076	81,905	5,821	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.174788	17,700	3,094	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.100599	260,621	26,218	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.330144	178,327	58,874	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.387714	402,324	155,987	73.00
74.00	07400	RENAL DIALYSIS	0.260224	36,556	9,513	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.361280	0	0	76.00
76.01	03190	CHEMOTHERAPY	0.421241	2,508	1,056	76.01
76.02	03330	ENDOSCOPY	1.116775	3,096	3,458	76.02
76.03	03950	WOUND CARE CENTER	0.091106	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.106734	794,794	84,832	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.495567	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	98.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		4,830,339	770,536	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)		4,830,339		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-0010 | Component CCN: 15-T010 | Period: From 07/01/2021 To 06/30/2022 | Worksheet D-3 | Date/Time Prepared: 11/28/2022 1:52 pm

Title XIX | Subprovider - IRF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
41.00	04100	SUBPROVIDER - IRF		30,352		41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.121302	403	49	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.200411	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.242519	496	120	54.00
54.01	03630	ULTRA SOUND	0.106718	567	61	54.01
56.00	05600	RADIOISOTOPE	0.104135	0	0	56.00
57.00	05700	CT SCAN	0.080874	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.292163	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	1.910314	0	0	59.00
60.00	06000	LABORATORY	0.100019	15,666	1,567	60.00
65.00	06500	RESPIRATORY THERAPY	0.182162	3,673	669	65.00
66.00	06600	PHYSICAL THERAPY	0.334296	5,804	1,940	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.341975	6,378	2,181	67.00
68.00	06800	SPEECH PATHOLOGY	0.379390	2,728	1,035	68.00
69.00	06900	ELECTROCARDIOLOGY	0.071076	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.174788	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.100599	28	3	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.330144	676	223	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.387714	5,482	2,125	73.00
74.00	07400	RENAL DIALYSIS	0.260224	16,344	4,253	74.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.361280	0	0	76.00
76.01	03190	CHEMOTHERAPY	0.421241	0	0	76.01
76.02	03330	ENDOSCOPY	1.116775	0	0	76.02
76.03	03950	WOUND CARE CENTER	0.091106	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.106734	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.495567	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	98.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		58,245	14,226	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)		58,245		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0010	Period: From 07/01/2021 To 06/30/2022	Worksheet E Part A Date/Time Prepared: 11/28/2022 1:52 pm
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		1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		
1.00	DRG Amounts Other than Outlier Payments	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	2,961,788	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	9,056,013	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)	0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)	0	1.04
2.00	Outlier payments for discharges. (see instructions)		2.00
2.01	Outlier reconciliation amount	0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)	0	2.02
2.03	Outlier payments for discharges occurring prior to October 1 (see instructions)	71,185	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)	229,596	2.04
3.00	Managed Care Simulated Payments	0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	116.52	4.00
	Indirect Medical Education Adjustment		
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)	0.00	5.00
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)	0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.	0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.	0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)	0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)	0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.	0.00	11.00
12.00	Current year allowable FTE (see instructions)	0.00	12.00
13.00	Total allowable FTE count for the prior year.	0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.	0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.	0.00	15.00
16.00	Adjustment for residents in initial years of the program	0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure	0.00	17.00
18.00	Adjusted rolling average FTE count	0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)	0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.000000	21.00
22.00	IME payment adjustment (see instructions)	0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)	0	22.01
	Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA		
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).	0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)	0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)	0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)	0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)	0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)	0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)	0	28.01
29.00	Total IME payment (sum of lines 22 and 28)	0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	0	29.01
	Disproportionate Share Adjustment		
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	2.87	30.00
31.00	Percentage of Medicaid patient days (see instructions)	22.11	31.00
32.00	Sum of lines 30 and 31	24.98	32.00
33.00	Allowable disproportionate share percentage (see instructions)	9.82	33.00
34.00	Disproportionate share adjustment (see instructions)	295,037	34.00

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		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	Uncompensated Care Adjustment			
35.00	Total uncompensated care amount (see instructions)	8,290,014,521	7,192,008,710	35.00
35.01	Factor 3 (see instructions)	0.000232246	0.000200783	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	1,925,321	1,444,033	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	485,287	1,080,057	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	1,565,344		36.00
	Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)			
40.00	Total Medicare discharges (see instructions)	0		40.00
		Before 1/1	On/After 1/1	
		1.00	1.01	
41.00	Total ESRD Medicare discharges (see instructions)	0	0	41.00
41.01	Total ESRD Medicare covered and paid discharges (see instructions)	0	0	41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days (see instructions)	0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00	0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00
47.00	Subtotal (see instructions)	14,178,963		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	0		48.00

		Amount	
		1.00	
49.00	Total payment for inpatient operating costs (see instructions)	14,178,963	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	966,568	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)	0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).	0	52.00
53.00	Nursing and Allied Health Managed Care payment	3,830	53.00
54.00	Special add-on payments for new technologies	276,650	54.00
54.01	Islet isolation add-on payment	0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)	0	55.00
56.00	Cost of physicians' services in a teaching hospital (see intructions)	0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).	0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)	16,830	58.00
59.00	Total (sum of amounts on lines 49 through 58)	15,442,841	59.00
60.00	Primary payer payments	0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	15,442,841	61.00
62.00	Deductibles billed to program beneficiaries	1,422,620	62.00
63.00	Coinsurance billed to program beneficiaries	16,565	63.00
64.00	Allowable bad debts (see instructions)	105,647	64.00
65.00	Adjusted reimbursable bad debts (see instructions)	68,671	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	15,780	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	14,072,327	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)	0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)	0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	70.00
70.50	Rural Community Hospital Demonstration Project (§410A Demonstration) adjustment (see instructions)	0	70.50
70.87	Demonstration payment adjustment amount before sequestration	0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)	0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)	0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)	0	70.91
70.92	Bundled Model 1 discount amount (see instructions)	0	70.92
70.93	HVBP payment adjustment amount (see instructions)	-2,464	70.93
70.94	HRR adjustment amount (see instructions)	-4,622	70.94
70.95	Recovery of accelerated depreciation	0	70.95

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		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		14,065,241	71.00
71.01	Sequestration adjustment (see instructions)		35,163	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
71.03	Sequestration adjustment-PARHM pass-throughs			71.03
72.00	Interim payments		13,760,177	72.00
72.01	Interim payments-PARHM			72.01
73.00	Tentative settlement (for contractor use only)		0	73.00
73.01	Tentative settlement-PARHM (for contractor use only)			73.01
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		269,901	74.00
74.01	Balance due provider/program-PARHM (see instructions)			74.01
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		214,102	75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00

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

LOW VOLUME CALCULATION EXHIBIT 4	Provider CCN: 15-0010	Period: From 07/01/2021 To 06/30/2022	Worksheet E Part A Exhibit 4 Date/Time Prepared: 11/28/2022 1:52 pm
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		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	2,961,788	0	2,961,788		2,961,788	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	9,056,013	0		9,056,013	9,056,013	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00						2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	71,185	0	71,185		71,185	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	229,596	0		229,596	229,596	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	0	4.00
	Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0	9.01
	Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0982	0.0982	0.0982	0.0982		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	295,037	0	72,712	222,325	295,037	11.00
11.01	Uncompensated care payments	36.00	1,565,344	0	485,287	1,080,056	1,565,343	11.01
	Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	14,178,963	0	3,590,972	10,587,991	14,178,963	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	14,178,963	0	3,590,972	10,587,991	14,178,963	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	966,568	0	240,255	726,313	966,568	16.00

LOW VOLUME CALCULATION EXHIBIT 4	Provider CCN: 15-0010	Period: From 07/01/2021 To 06/30/2022	Worksheet E Part A Exhibit 4 Date/Time Prepared: 11/28/2022 1:52 pm
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		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
17.00	Special add-on payments for new technologies	54.00	276,650	0	90,175	186,475	276,650	17.00
17.01	Net organ aquisition cost							17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			0	3,921,402	11,500,779	15,422,181	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	901,496	0	224,146	677,350	901,496	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	18,284	0	4,476	13,808	18,284	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0519	0.0519	0.0519	0.0519		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	46,788	0	11,633	35,155	46,788	25.00
26.00	Total prospective capital payments (see instructions)	12.00	966,568	0	240,255	726,313	966,568	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.000000	0.000000		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			0		0	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				0	0	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 15-0010 | Period: From 07/01/2021 To 06/30/2022 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 11/28/2022 1:52 pm

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		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	2,961,788	2,961,788		2,961,788	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	9,056,013		9,056,013	9,056,013	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00					2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	71,185	71,185		71,185	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	229,596		229,596	229,596	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	4.00
	Indirect Medical Education Adjustment						
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA						
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
	Disproportionate Share Adjustment						
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0982	0.0982	0.0982		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	295,037	72,712	222,325	295,037	11.00
11.01	Uncompensated care payments	36.00	1,565,344	485,287	1,080,056	1,565,343	11.01
	Additional payment for high percentage of ESRD beneficiary discharges						
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	14,178,963	3,590,972	10,587,991	14,178,963	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	14,178,963	3,590,972	10,587,991	14,178,963	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	966,568	240,255	726,313	966,568	16.00
17.00	Special add-on payments for new technologies	54.00	276,650	90,175	186,475	276,650	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			3,921,402	11,500,779	15,422,181	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5	Provider CCN: 15-0010	Period: From 07/01/2021 To 06/30/2022	Worksheet E Part A Exhibit 5 Date/Time Prepared: 11/28/2022 1:52 pm
	Title XVIII	Hospital	PPS

		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	901,496	224,146	677,350	901,496	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	18,284	4,476	13,808	18,284	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0519	0.0519	0.0519		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	46,788	11,633	35,155	46,788	25.00
26.00	Total prospective capital payments (see instructions)	12.00	966,568	240,255	726,313	966,568	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	0	0		0	28.00
29.00	Low volume adjustment on or after October 1	70.97	0		0	0	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	-2,464	-2,464	0	-2,464	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	-4,622	0	-4,622	-4,622	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	0	0	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0010	Period: From 07/01/2021 To 06/30/2022	Worksheet E Part B Date/Time Prepared: 11/28/2022 1:52 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	2,057	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	17,417,653	2.00
3.00	OPPS payments	15,451,298	3.00
4.00	Outlier payment (see instructions)	120,903	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	85,667	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	2,057	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	5,306	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)	5,306	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)	5,306	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	3,249	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)	2,057	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)	15,657,868	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	2,776,288	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)	12,883,637	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)	12,883,637	30.00
31.00	Primary payer payments	113	31.00
32.00	Subtotal (line 30 minus line 31)	12,883,524	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)	168,419	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	109,472	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	70,192	36.00
37.00	Subtotal (see instructions)	12,992,996	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)	12,992,996	40.00
40.01	Sequestration adjustment (see instructions)	32,482	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	13,046,388	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)	-85,874	43.00
43.01	Balance due provider/program-PARHM (see instructions)		43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0010	Period: From 07/01/2021 To 06/30/2022	Worksheet E Part B Date/Time Prepared: 11/28/2022 1:52 pm
	Title XVIII	Hospital	PPS

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-0010 | Period: From 07/01/2021 To 06/30/2022 | Worksheet E-1 Part I | Date/Time Prepared: 11/28/2022 1:52 pm

Title XVIII | Hospital | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		13,760,177		13,046,388	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)		13,760,177		13,046,388	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		269,901		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		85,874	6.02
7.00	Total Medicare program liability (see instructions)		14,030,078		12,960,514	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: 15-0010 Component CCN: 15-T010	Period: From 07/01/2021 To 06/30/2022	Worksheet E-1 Part I Date/Time Prepared: 11/28/2022 1:52 pm
	Title XVIII	Subprovider - IRF	PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		3,482,255		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)		3,482,255		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		3,408		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		3,485,663		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: 15-0010	Period: From 07/01/2021 To 06/30/2022	Worksheet E-1 Part II Date/Time Prepared: 11/28/2022 1:52 pm
	Title XVIII	Hospital	PPS

		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14		1.00
2.00	Medicare days (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

Provider CCN: 15-0010 | Component CCN: 15-T010 | Period: From 07/01/2021 To 06/30/2022 | Worksheet E-3 Part III | Date/Time Prepared: 11/28/2022 1:52 pm

Title XVIII | Subprovider - IRF | PPS

		1.00	
	PART III - MEDICARE PART A SERVICES - IRF PPS		
1.00	Net Federal PPS Payment (see instructions)	3,421,947	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)	0.0326	2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)	112,240	3.00
4.00	Outlier Payments	0	4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)	0.00	5.00
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00	5.01
6.00	New Teaching program adjustment. (see instructions)	0.00	6.00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)	0.00	7.00
8.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)	0.00	8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)	0.00	9.00
10.00	Average Daily Census (see instructions)	9.545205	10.00
11.00	Teaching Adjustment Factor (see instructions)	0.000000	11.00
12.00	Teaching Adjustment (see instructions)	0	12.00
13.00	Total PPS Payment (see instructions)	3,534,187	13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)	0	14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)		15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)	0	16.00
17.00	Subtotal (see instructions)	3,534,187	17.00
18.00	Primary payer payments	10,000	18.00
19.00	Subtotal (line 17 less line 18).	3,524,187	19.00
20.00	Deductibles	19,652	20.00
21.00	Subtotal (line 19 minus line 20)	3,504,535	21.00
22.00	Coinsurance	11,418	22.00
23.00	Subtotal (line 21 minus line 22)	3,493,117	23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	990	24.00
25.00	Adjusted reimbursable bad debts (see instructions)	644	25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	26.00
27.00	Subtotal (sum of lines 23 and 25)	3,493,761	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	28.00
29.00	Other pass through costs (see instructions)	638	29.00
30.00	Outlier payments reconciliation	0	30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	31.00
31.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	31.50
31.98	Recovery of accelerated depreciation.	0	31.98
31.99	Demonstration payment adjustment amount before sequestration	0	31.99
32.00	Total amount payable to the provider (see instructions)	3,494,399	32.00
32.01	Sequestration adjustment (see instructions)	8,736	32.01
32.02	Demonstration payment adjustment amount after sequestration	0	32.02
33.00	Interim payments	3,482,255	33.00
34.00	Tentative settlement (for contractor use only)	0	34.00
35.00	Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)	3,408	35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	36.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4	0	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money	0.00	52.00
53.00	Time Value of Money (see instructions)	0	53.00
	FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING BEFORE THE END OF THE COVID-19 PHE		
99.00	Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020.	0.000000	99.00
99.01	Calculated Teaching Adjustment Factor for the current year. (see instructions)	0.000000	99.01

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0010 | Period: From 07/01/2021 To 06/30/2022 | Worksheet E-3 Part VII Date/Time Prepared: 11/28/2022 1:52 pm

Title XIX | Hospital | Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	1,593,443		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)	1,593,443	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	1,593,443	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	4,830,339	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)	4,830,339	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)	4,830,339	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	3,236,896	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	1,593,443	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	1,593,443	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	1,593,443	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	1,593,443	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	1,593,443	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	1,593,443	0	40.00
41.00	Interim payments	1,593,443	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

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 15-0010 | Component CCN: 15-T010 | Period: From 07/01/2021 To 06/30/2022 | Worksheet E-3 Part VII | Date/Time Prepared: 11/28/2022 1:52 pm

Title XIX | Subprovider - IRF | Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	28,733		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)	28,733	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)	28,733	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	58,245	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)	58,245	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)	58,245	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	29,512	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)	28,733	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)	28,733	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)	28,733	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)	28,733	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	28,733	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)	28,733	0	40.00
41.00	Interim payments	28,733	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: 15-0010 | Period: From 07/01/2021 To 06/30/2022 | Worksheet G | Date/Time Prepared: 11/28/2022 1:52 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	17,039	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	21,728,844	0	0	0	4.00
5.00	Other receivable	3,248,834	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	2,361,203	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	222,306	0	0	0	9.00
10.00	Due from other funds	69,376	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	27,647,602	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	671,919	0	0	0	12.00
13.00	Land improvements	2,316,541	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	82,859,559	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	653,423	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	20,718,982	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	1,628,533	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	50,113,349	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	-124,618,142	0	0	0	28.00
29.00	Minor equipment-nondepreciable	2,061,345	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	36,405,509	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	175,068	0	0	0	31.00
32.00	Deposits on leases	1,137,539	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	32,534	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	1,345,141	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	65,398,252	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	4,012,360	0	0	0	37.00
38.00	Salaries, wages, and fees payable	3,214,033	0	0	0	38.00
39.00	Payroll taxes payable	704,073	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	15,892,216	0	0	0	43.00
44.00	Other current liabilities	6,415,121	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	30,237,803	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	5,068,092	0	0	0	47.00
48.00	Unsecured loans	14,446,166	0	0	0	48.00
49.00	Other long term liabilities	2,985,539	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	22,499,797	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	52,737,600	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	12,660,652				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)	12,660,652	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	65,398,252	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 15-0010 | Period: From 07/01/2021 To 06/30/2022 | Worksheet G-1 | Date/Time Prepared: 11/28/2022 1:52 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		1,461,360		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		25,555,661				2.00
3.00	Total (sum of line 1 and line 2)		27,017,021		0		3.00
4.00	OTHER ACTIVITY	175,068		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		175,068		0		10.00
11.00	Subtotal (line 3 plus line 10)		27,192,089		0		11.00
12.00	TRANSFER TO ALPHA	14,531,438		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)		14,531,438		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		12,660,651		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	OTHER ACTIVITY		0		4.00
5.00			0		5.00
6.00			0		6.00
7.00			0		7.00
8.00			0		8.00
9.00			0		9.00
10.00	Total additions (sum of line 4-9)	0		0	10.00
11.00	Subtotal (line 3 plus line 10)	0		0	11.00
12.00	TRANSFER TO ALPHA		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: 15-0010 | Period: From 07/01/2021 To 06/30/2022 | Worksheet G-2 Parts I & II | Date/Time Prepared: 11/28/2022 1:52 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	33,455,167		33,455,167	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF	7,212,063		7,212,063	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)	40,667,230		40,667,230	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	13,047,820		13,047,820	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	13,047,820		13,047,820	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	53,715,050		53,715,050	17.00
18.00	Ancillary services	170,298,886	0	170,298,886	18.00
19.00	Outpatient services	0	381,071,628	381,071,628	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	3,788	19,929,827	19,933,615	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PHYSICIAN PRIVATE OFFICE	458,200	955,657	1,413,857	27.00
27.01	CLINIC OF HOPE	0	146,073	146,073	27.01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	224,475,924	402,103,185	626,579,109	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		153,697,934		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)		153,697,934		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-0010 | Period: From 07/01/2021 To 06/30/2022 | Worksheet G-3 | Date/Time Prepared: 11/28/2022 1:52 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	626,579,109	1.00
2.00	Less contractual allowances and discounts on patients' accounts	451,461,993	2.00
3.00	Net patient revenues (line 1 minus line 2)	175,117,116	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	153,697,934	4.00
5.00	Net income from service to patients (line 3 minus line 4)	21,419,182	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	368,048	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	1,066	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	1,811	21.00
22.00	Rental of hospital space	110,840	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISCELLANEOUS REVENUE	218,805	24.00
24.01	IC RENTAL INCOME	124,596	24.01
24.02	FOUNDATION IC TRANSFER	167,646	24.02
24.03	GAIN/(LOSS) ON DISPOSAL OF ASSETS	-6,328	24.03
24.04	PATIENT INTEREST INCOME	7,378	24.04
24.05	MEDICAL AFFAIRS ADMINISTRATIVE FEES	216,631	24.05
24.06	SEMINARS TUITION REVENUE	15,545	24.06
24.07	IIUE INCOME LOSS	43,395	24.07
24.08	IC SHARED SAVINGS REVENUE ACO	265,338	24.08
24.09	STATE SPONSORED PROJECT REVENUE	81,269	24.09
24.10	FEDERAL SPONSORED PROJECT REVENUE	456,749	24.10
24.11	RENTAL INCOME	346,258	24.11
24.12	MEALS ON WHEELS	74,090	24.12
24.50	COVID-19 PHE Funding	1,643,342	24.50
25.00	Total other income (sum of lines 6-24)	4,136,479	25.00
26.00	Total (line 5 plus line 25)	25,555,661	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)	25,555,661	29.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 15-0010	Period: From 07/01/2021 To 06/30/2022	Worksheet L Parts I-III Date/Time Prepared: 11/28/2022 1:52 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	901,496	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	18,284	2.00
2.01	Model 4 BPCI Capital DRG outlier payments	0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)	52.24	3.00
4.00	Number of interns & residents (see instructions)	0.00	4.00
5.00	Indirect medical education percentage (see instructions)	0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)	0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	2.87	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	22.11	8.00
9.00	Sum of lines 7 and 8	24.98	9.00
10.00	Allowable disproportionate share percentage (see instructions)	5.19	10.00
11.00	Disproportionate share adjustment (see instructions)	46,788	11.00
12.00	Total prospective capital payments (see instructions)	966,568	12.00

		1.00	
	PART II - PAYMENT UNDER REASONABLE COST		
1.00	Program inpatient routine capital cost (see instructions)	0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)	0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)	0	3.00
4.00	Capital cost payment factor (see instructions)	0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)	0	5.00

		1.00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS		
1.00	Program inpatient capital costs (see instructions)	0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)	0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)	0	3.00
4.00	Applicable exception percentage (see instructions)	0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)	0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)	0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)	0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)	0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)	0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)	0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)	0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)	0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)	0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)	0	14.00
15.00	Current year allowable operating and capital payment (see instructions)	0	15.00
16.00	Current year operating and capital costs (see instructions)	0	16.00
17.00	Current year exception offset amount (see instructions)	0	17.00