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: 15-3025	Period: From 01/01/2022 To 07/31/2022	Worksheet S Parts I-III Date/Time Prepared: 11/22/2022 12:05 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 11/22/2022 Time: 12:05 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 ENCOMPASS HEALTH DEACONESS REHABILIT (15-3025) for the cost reporting period beginning 01/01/2022 and ending 07/31/2022 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR		CHECKBOX	ELECTRONIC SIGNATURE STATEMENT	
	1		2		
1	Rob Wisner		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	Rob Wisner			2
3	Signatory Title	SVP - REIMBURSEMENT			3
4	Date	11/22/2022 12:05:58 PM			4

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	56,075	-3	0	58,862	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing Bed - SNF	0	0	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
200.00	Total	0	56,075	-3	0	58,862	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: 15-3025 | Period: From 01/01/2022 To 07/31/2022 | Worksheet S-2 Part I | Date/Time Prepared: 11/22/2022 12:05 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 9355 WARRICK TRAIL	PO Box:			1.00
2.00	City: NEWBURGH	State: IN	Zip Code: 47630	County: VANDERBURGH	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	ENCOMPASS HEALTH DEACONESS REHABILIT	153025	21780	5	06/08/1989	N	P	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									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)	01/01/2022	07/31/2022	20.00
21.00	Type of Control (see instructions)	5		21.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-3025 | Period: From 01/01/2022 To 07/31/2022 | Worksheet S-2 Part I Date/Time Prepared: 11/22/2022 12:05 pm

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	0	0	0	0	0	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	197	241	35	166	1,991		25.00

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	1		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	1		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00
		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)			37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.			38.00
		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40.00

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

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-3025 | Period: From 01/01/2022 To 07/31/2022 | Worksheet S-2 Part I Date/Time Prepared: 11/22/2022 12:05 pm

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-3025	Period: From 01/01/2022 To 07/31/2022	Worksheet S-2 Part I Date/Time Prepared: 11/22/2022 12:05 pm

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	25,161	1,980	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	N		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	HB1911	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-3025 | Period: From 01/01/2022 To 07/31/2022 | Worksheet S-2 Part I | Date/Time Prepared: 11/22/2022 12:05 pm

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name: ENCOMPASS HEALTH	Contractor's Name: PALMETTO	Contractor's Number: 10101	141.00
142.00	Street: 9001 LIBERTY PARKWAY	PO Box:		142.00
143.00	City: BIRMINGHAM	State: AL	Zip Code: 35242	143.00

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

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

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

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

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-3025 | Period: From 01/01/2022 To 07/31/2022 | Worksheet S-2 Part II Date/Time Prepared: 11/22/2022 12:05 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)	N			3.00

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	02/25/2022	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	N	10/04/2022	Y	10/04/2022	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)	Y	10/04/2022	N	10/04/2022	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: 15-3025	Period: From 01/01/2022 To 07/31/2022	Worksheet S-2 Part II Date/Time Prepared: 11/22/2022 12:05 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?			36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			40.00

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	MATTHEW	LALLONE	41.00
42.00	Enter the employer/company name of the cost report preparer.	ENCOMPASS HEALTH CORPORATION		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	205-968-7055	MATTHEW.LALLONE@ENCOMPASSHEALTH.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-3025 | Period: From 01/01/2022 To 07/31/2022 | Worksheet S-2 Part II | Date/Time Prepared: 11/22/2022 12:05 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.	SR. REIMBURSEMENT ACCOUNTANT		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: 15-3025 | Period: From 01/01/2022 To 07/31/2022 | Worksheet S-3 Part I | Date/Time Prepared: 11/22/2022 12:05 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	20,776	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	20,776	0.00	0	7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		98	20,776	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		98				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-3025 | Period: From 01/01/2022 To 07/31/2022 | Worksheet S-3 Part I Date/Time Prepared: 11/22/2022 12:05 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)	9,459	170	19,359			1.00
2.00	HMO and other (see instructions)	4,500	2,460				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	9,459	170	19,359			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)	9,459	170	19,359	0.00	263.51	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	263.51	27.00
28.00	Observation Bed Days		0	0			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-3025 | Period: From 01/01/2022 To 07/31/2022 | Worksheet S-3 Part I | Date/Time Prepared: 11/22/2022 12:05 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	740	15	1,450	1.00
2.00	HMO and other (see instructions)			319	183		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	740	15	1,450	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	10,361,509	0	10,361,509	318,336.99	32.55	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		66,630	0	66,630	489.00	136.26	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician and Non Physician-Part B		0	0	0	0.00	0.00	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		0	102,747	102,747	2,561.05	40.12	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		509,031	0	509,031	6,473.97	78.63	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		68,345	-1,715	66,630	489.00	136.26	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		559,986	0	559,986	10,263.70	54.56	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)		2,348,451	0	2,348,451			17.00
18.00	Wage-related costs (other) (see instructions)							18.00
19.00	Excluded areas		23,521	0	23,521			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		0	0	0			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
25.50	Home office wage-related (core)		239,810	0	239,810			25.50
25.51	Related organization wage-related (core)		0	0	0			25.51
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0			25.52

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-3025 | Period: From 01/01/2022 To 07/31/2022 | Worksheet S-3 Part II Date/Time Prepared: 11/22/2022 12:05 pm

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.53	Home office: Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	0	0	0	0.00	0.00	26.00
27.00	Administrative & General	5.00	1,415,219	-102,747	1,312,472	34,213.82	38.36	27.00
28.00	Administrative & General under contract (see inst.)		26,170	0	26,170	224.00	116.83	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	179,881	0	179,881	6,475.47	27.78	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	197,603	0	197,603	12,491.86	15.82	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	297,608	0	297,608	14,956.40	19.90	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	0	0	0.00	0.00	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	618,377	0	618,377	14,992.65	41.25	38.00
39.00	Central Services and Supply	14.00	0	0	0	0.00	0.00	39.00
40.00	Pharmacy	15.00	0	0	0	0.00	0.00	40.00
41.00	Medical Records & Medical Records Library	16.00	63,064	0	63,064	3,201.49	19.70	41.00
42.00	Social Service	17.00	397,561	0	397,561	11,416.64	34.82	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-3025 | Period: From 01/01/2022 To 07/31/2022 | Worksheet S-3 Part III Date/Time Prepared: 11/22/2022 12:05 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)		10,387,679	0	10,387,679	318,560.99	32.61	1.00
2.00	Excluded area salaries (see instructions)		0	102,747	102,747	2,561.05	40.12	2.00
3.00	Subtotal salaries (line 1 minus line 2)		10,387,679	-102,747	10,284,932	315,999.94	32.55	3.00
4.00	Subtotal other wages & related costs (see inst.)		1,137,362	-1,715	1,135,647	17,226.67	65.92	4.00
5.00	Subtotal wage-related costs (see inst.)		2,588,261	0	2,588,261	0.00	25.17	5.00
6.00	Total (sum of lines 3 thru 5)		14,113,302	-104,462	14,008,840	333,226.61	42.04	6.00
7.00	Total overhead cost (see instructions)		3,195,483	-102,747	3,092,736	97,972.33	31.57	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 15-3025 | Period: From 01/01/2022 To 07/31/2022 | Worksheet S-3 Part IV | Date/Time Prepared: 11/22/2022 12:05 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	167,883	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	1,728,723	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	11,665	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	0	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	90,947	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	761,044	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	28,725	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	-417,014	22.00
23.00	Tuition Reimbursement	0	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	2,371,973	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: 15-3025 | Period: From 01/01/2022 To 07/31/2022 | Worksheet S-3 Part V Date/Time Prepared: 11/22/2022 12:05 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	575,661	2,371,972	1.00
2.00	Hospital	575,661	2,348,451	2.00
3.00	SUBPROVIDER - IPF			3.00
4.00	SUBPROVIDER - IRF			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			17.00
18.00	Other	0	23,521	18.00

HOSPITAL RENAL DIALYSIS DEPARTMENT STATISTICAL DATA | Provider CCN: 15-3025 | Period: From 01/01/2022 To 07/31/2022 | Worksheet S-5 | Date/Time Prepared: 11/22/2022 12:05 pm

		Outpatient		Training		Home		
		Regular	High Flux	Hemodialysis	CAPD / CCPD	Hemodialysis	CAPD / CCPD	
		1.00	2.00	3.00	4.00	5.00	6.00	
1.00	Number of patients in program at end of cost reporting period	0	0	0	0	0	0	1.00
2.00	Number of times per week patient receives dialysis	0.00	0.00	0.00	0.00	0.00	0.00	2.00
3.00	Average patient dialysis time including setup	0.00	0.00	0.00	0.00			3.00
4.00	CAPD exchanges per day				0.00		0.00	4.00
5.00	Number of days in year dialysis furnished	0	0					5.00
6.00	Number of stations	0	0	0	0			6.00
7.00	Treatment capacity per day per station	0	0					7.00
8.00	Utilization (see instructions)	0.00	0.00					8.00
9.00	Average times dialyzers re-used	0.00	0.00					9.00
10.00	Percentage of patients re-using dialyzers	0.00	0.00					10.00

		Y/N	
		1.00	
	ESRD PPS		
10.01	Is the dialysis facility approved as a low-volume facility for this cost reporting period? Enter "Y" for yes or "N" for no. (see instructions)	N	10.01
10.02	Did your facility elect 100% PPS effective January 1, 2011? Enter "Y" for yes or "N" for no. (See instructions for "new" providers.)	Y	10.02

		Prior to 1/1	After 12/31	
		1.00	2.00	
10.03	If you responded "N" to line 10.02, enter in column 1 the year of transition for periods prior to January 1 and enter in column 2 the year of transition for periods after December 31. (see instructions)	0	4	10.03
	TRANSPLANT INFORMATION			
11.00	Number of patients on transplant list	0		11.00
12.00	Number of patients transplanted during the cost reporting period	0		12.00
	EPOETIN			
13.00	Net costs of Epoetin furnished to all maintenance dialysis patients by the provider.			13.00
14.00	Epoetin amount from Worksheet A for Home Dialysis program			14.00
15.00	Number of EPO units furnished relating to the renal dialysis department			15.00
16.00	Number of EPO units furnished relating to the home dialysis department			16.00
	ARANESP			
17.00	Net costs of ARANESP furnished to all maintenance dialysis patients by the provider.			17.00
18.00	ARANESP amount from Worksheet A for Home Dialysis program			18.00
19.00	Number of ARANESP units furnished relating to the renal dialysis department			19.00
20.00	Number of ARANESP units furnished relating to the home dialysis department			20.00

		MCP	INITIAL METHOD	
		1.00	2.00	
	PHYSICIAN PAYMENT METHOD			
21.00	Enter "X" if method(s) is applicable			21.00

		ESA Description	Net Cost of ESAs for Renal Patients	Net Cost of ESAs for Home Patients	Number of ESA Units - Renal Dialysis Dept.	Number of ESA Units - Home Dialysis Dept.	
		1.00	2.00	3.00	4.00	5.00	
	ESAs						
22.00	Enter in column 1 the ESA description. Enter in column 2 the net costs of ESAs furnished to all renal dialysis patients. Enter in column 3 the net cost of ESAs furnished to all home dialysis program patients. Enter in column 4 the number of ESA units furnished to patients in the renal dialysis department. Enter in column 5 the number of units furnished to patients in the home dialysis program. (see instructions)		0	0	0	0	22.00

HOSPITAL RENAL DIALYSIS DEPARTMENT STATISTICAL DATA	Provider CCN: 15-3025	Period: From 01/01/2022 To 07/31/2022	Worksheet S-5 Date/Time Prepared: 11/22/2022 12:05 pm

		CCN	Treatments	
		1.00	2.00	
23.00	If line 10.01 is yes, enter in column 1 the CCN for each renal dialysis facility listed on Worksheet S-2, Part I, line 18, and its subscripts. Enter in column 2, the total treatments for each CCN. (see instructions)		0	23.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-3025 | Period: From 01/01/2022 To 07/31/2022 | Worksheet A | Date/Time Prepared: 11/22/2022 12:05 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		1,079,627	1,079,627	158,119	1,237,746	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		594,077	594,077	38,335	632,412	2.00
3.00	00300	OTHER CAP REL COSTS		176,150	176,150	-176,150	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	2,168,981	2,168,981	0	2,168,981	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,415,219	2,753,005	4,168,224	-143,909	4,024,315	5.00
7.00	00700	OPERATION OF PLANT	179,881	463,125	643,006	0	643,006	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	188,556	188,556	0	188,556	8.00
9.00	00900	HOUSEKEEPING	197,603	44,180	241,783	0	241,783	9.00
10.00	01000	DIETARY	297,608	407,395	705,003	0	705,003	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	618,377	24,316	642,693	0	642,693	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	63,064	1,627	64,691	0	64,691	16.00
17.00	01700	SOCIAL SERVICE	397,561	7,203	404,764	0	404,764	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,245,043	872,827	5,117,870	17,630	5,135,500	30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	145,305	145,305	-51,699	93,606	54.00
54.01	05401	RADIOLOGY - SUA	0	0	0	51,699	51,699	54.01
60.00	06000	LABORATORY	0	456,263	456,263	0	456,263	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	273,454	4,922	278,376	0	278,376	65.00
66.00	06600	PHYSICAL THERAPY	866,443	94,123	960,566	-43,770	916,796	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,032,842	22,640	1,055,482	35,323	1,090,805	67.00
68.00	06800	SPEECH PATHOLOGY	336,146	4,643	340,789	8,447	349,236	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	48,674	181,491	230,165	0	230,165	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	389,594	390,345	779,939	0	779,939	73.00
76.00	03020	PSYCH	0	0	0	0	0	76.00
76.01	03951	SPECIAL PROCEDURES	0	84,667	84,667	-84,667	0	76.01
76.02	03950	SPECIAL PROCEDURES - SUA	0	0	0	84,667	84,667	76.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		2,914	2,914	0	2,914	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	10,361,509	10,168,382	20,529,891	-105,975	20,423,916	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	MARKETING NRCC	0	0	0	105,975	105,975	194.00
194.01	07951	GUEST MEALS	0	0	0	0	0	194.01
200.00		TOTAL (SUM OF LINES 118 through 199)	10,361,509	10,168,382	20,529,891	0	20,529,891	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-3025 | Period: From 01/01/2022 To 07/31/2022 | Worksheet A | Date/Time Prepared: 11/22/2022 12:05 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	193,141	1,430,887	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-45,880	586,532	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	188,886	2,357,867	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-746,300	3,278,015	5.00
7.00	00700	OPERATION OF PLANT	-29,745	613,261	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	188,556	8.00
9.00	00900	HOUSEKEEPING	-1,161	240,622	9.00
10.00	01000	DIETARY	-136,162	568,841	10.00
11.00	01100	CAFETERIA	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	-2,925	639,768	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-1,827	62,864	16.00
17.00	01700	SOCIAL SERVICE	0	404,764	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	-119,684	5,015,816	30.00
		ANCILLARY SERVICE COST CENTERS			
54.00	05400	RADIOLOGY-DIAGNOSTIC	-956	92,650	54.00
54.01	05401	RADIOLOGY - SUA	-23,707	27,992	54.01
60.00	06000	LABORATORY	-30,993	425,270	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	278,376	65.00
66.00	06600	PHYSICAL THERAPY	0	916,796	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,090,805	67.00
68.00	06800	SPEECH PATHOLOGY	0	349,236	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	-20,206	209,959	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-2,338	777,601	73.00
76.00	03020	PSYCH	0	0	76.00
76.01	03951	SPECIAL PROCEDURES	0	0	76.01
76.02	03950	SPECIAL PROCEDURES - SUA	-23,874	60,793	76.02
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS			
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	93.99
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE	-2,914	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-806,645	19,617,271	118.00
		NONREIMBURSABLE COST CENTERS			
194.00	07950	MARKETING NRCC	0	105,975	194.00
194.01	07951	GUEST MEALS	0	0	194.01
200.00		TOTAL (SUM OF LINES 118 through 199)	-806,645	19,723,246	200.00

RECLASSIFICATIONS | Provider CCN: 15-3025 | Period: From 01/01/2022 To 07/31/2022 | Worksheet A-6 | Date/Time Prepared: 11/22/2022 12:05 pm

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - INSURANCE				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	16,343	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	3,961	2.00
	TOTALS		0	20,304	
	B - MARKETING				
1.00	MARKETING NRCC	194.00	102,747	3,228	1.00
	TOTALS		102,747	3,228	
	C - PHYSICIANS				
1.00	ADULTS & PEDIATRICS	30.00	0	17,630	1.00
	TOTALS		0	17,630	
	D - SERVICE UNDER ARRANGEMENT				
1.00	RADIOLOGY - SUA	54.01	0	51,699	1.00
2.00	SPECIAL PROCEDURES - SUA	76.02	0	84,667	2.00
	TOTALS		0	136,366	
	E - DEPT 283 RECLASS				
1.00	OCCUPATIONAL THERAPY	67.00	35,058	265	1.00
2.00	SPEECH PATHOLOGY	68.00	8,383	64	2.00
	TOTALS		43,441	329	
500.00	Grand Total: Increases		146,188	177,857	500.00

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	20,304	12		1.00
2.00		0.00	0	0	12		2.00
	TOTALS		0	20,304			
	B - MARKETING						
1.00	ADMINISTRATIVE & GENERAL	5.00	102,747	3,228	0		1.00
	TOTALS		102,747	3,228			
	C - PHYSICIANS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	17,630	0		1.00
	TOTALS		0	17,630			
	D - SERVICE UNDER ARRANGEMENT						
1.00	RADIOLOGY-DIAGNOSTIC	54.00	0	51,699	0		1.00
2.00	SPECIAL PROCEDURES	76.01	0	84,667	0		2.00
	TOTALS		0	136,366			
	E - DEPT 283 RECLASS						
1.00	PHYSICAL THERAPY	66.00	43,441	329	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		43,441	329			
500.00	Grand Total: Decreases		146,188	177,857			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-3025 | Period: From 01/01/2022 To 07/31/2022 | Worksheet A-7 Part I Date/Time Prepared: 11/22/2022 12:05 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	1,675,024	0	0	0	0	1.00
2.00	Land Improvements	356,682	0	0	0	0	2.00
3.00	Buildings and Fixtures	24,941,419	0	0	0	0	3.00
4.00	Building Improvements	1,826,219	0	0	0	0	4.00
5.00	Fixed Equipment	6,231,859	0	0	0	0	5.00
6.00	Movable Equipment	94,584	259,021	0	259,021	9,158	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	35,125,787	259,021	0	259,021	9,158	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	35,125,787	259,021	0	259,021	9,158	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	1,675,024	0	1.00
2.00	Land Improvements	356,682	0	2.00
3.00	Buildings and Fixtures	24,941,419	0	3.00
4.00	Building Improvements	1,826,219	0	4.00
5.00	Fixed Equipment	6,231,859	0	5.00
6.00	Movable Equipment	344,447	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	35,375,650	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	35,375,650	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-3025 | Period: From 01/01/2022 To 07/31/2022 | Worksheet A-7 Part II | Date/Time Prepared: 11/22/2022 12:05 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	816,278	263,349	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	444,999	149,078	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,261,277	412,427	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL		
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	1,079,627	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	594,077	2.00
3.00	Total (sum of lines 1-2)	0	1,673,704	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-3025 | Period: From 01/01/2022 To 07/31/2022 | Worksheet A-7 Part III Date/Time Prepared: 11/22/2022 12:05 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	27,124,320	0	27,124,320	0.804861	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	6,576,306	0	6,576,306	0.195139	0	2.00
3.00	Total (sum of lines 1-2)	33,700,626	0	33,700,626	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	141,776	0	141,776	860,641	263,349	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	34,374	0	34,374	403,589	144,608	2.00
3.00	Total (sum of lines 1-2)	176,150	0	176,150	1,264,230	407,957	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	148,778	16,343	141,776	0	1,430,887	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	3,961	34,374	0	586,532	2.00
3.00	Total (sum of lines 1-2)	148,778	20,304	176,150	0	2,017,419	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-3025 | Period: From 01/01/2022 To 07/31/2022 | Worksheet A-8 | Date/Time Prepared: 11/22/2022 12:05 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-3,496			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	-487,852			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests		0		0.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-3025 | Period: From 01/01/2022 To 07/31/2022 | Worksheet A-8 | Date/Time Prepared: 11/22/2022 12:05 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	
33.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.00
37.00	INTEREST	A	-2,914	INTEREST EXPENSE	113.00	11	37.00
37.01	DEPRECIATION	A	-11,035	CAP REL COSTS-BLDG & FIXT	1.00	9	37.01
37.02	DEPRECIATION	A	13,418	CAP REL COSTS-MVBLE EQUIP	2.00	9	37.02
37.03	INSURANCE	A	197,553	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	37.03
37.04	INSURANCE	A	-208,460	ADMINISTRATIVE & GENERAL	5.00	0	37.04
37.05	NON-ALLOWABLE EXPENSES ADJUSTME	A	-25,039	ADMINISTRATIVE & GENERAL	5.00	0	37.05
37.06	NON-ALLOWABLE EXPENSES ADJUSTME	A	-7,676	DIETARY	10.00	0	37.06
37.07	NON-ALLOWABLE EXPENSES ADJUSTME	A	-2,925	NURSING ADMINISTRATION	13.00	0	37.07
37.08	NON-ALLOWABLE EXPENSES ADJUSTME	A	-74	RADIOLOGY-DIAGNOSTIC	54.00	0	37.08
37.09	NON-ALLOWABLE EXPENSES ADJUSTME	A	-20	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	37.09
37.10	PATIENT TELEPHONE	A	-5,765	CAP REL COSTS-MVBLE EQUIP	2.00	9	37.10
37.11	PATIENT TELEPHONE	A	-2,578	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	37.11
37.12	PATIENT TELEPHONE	A	-13,395	ADMINISTRATIVE & GENERAL	5.00	0	37.12
37.13	PATIENT TELEVISION	A	-40,476	CAP REL COSTS-MVBLE EQUIP	2.00	9	37.13
37.14	PATIENT TELEVISION	A	-2,699	OPERATION OF PLANT	7.00	0	37.14
37.15	PRINTING	A	-3,379	ADMINISTRATIVE & GENERAL	5.00	0	37.15
37.16	LOBBYING EXPENSE	A	-748	ADMINISTRATIVE & GENERAL	5.00	0	37.16
37.17	MISCELLANEOUS INCOME	B	-22	ADMINISTRATIVE & GENERAL	5.00	0	37.17
37.18	MISCELLANEOUS INCOME	B	-442	OPERATION OF PLANT	7.00	0	37.18
37.19	MISCELLANEOUS INCOME	B	-34,682	DIETARY	10.00	0	37.19
37.20	MISCELLANEOUS INCOME	B	-1,827	MEDICAL RECORDS & LIBRARY	16.00	0	37.20
37.21	PATIENT TRANSPORTATION	A	-8,587	CAP REL COSTS-MVBLE EQUIP	2.00	9	37.21
37.22	PATIENT TRANSPORTATION	A	-6,089	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	37.22
37.23	PATIENT TRANSPORTATION	A	-45	ADMINISTRATIVE & GENERAL	5.00	0	37.23
37.24	PATIENT TRANSPORTATION	A	-26,604	OPERATION OF PLANT	7.00	0	37.24
37.25	PATIENT TRANSPORTATION	A	-112,802	ADULTS & PEDIATRICS	30.00	0	37.25
37.26	PATIENT TRANSPORTATION	A	-221	DRUGS CHARGED TO PATIENTS	73.00	0	37.26
37.27	PROFESSIONAL FEES	A	-6,049	ADMINISTRATIVE & GENERAL	5.00	0	37.27
37.28	PHYSICIANS	A	-1,715	ADMINISTRATIVE & GENERAL	5.00	0	37.28
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-806,645				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: 15-3025 | Period: From 01/01/2022 To 07/31/2022 | Worksheet A-8-1 | Date/Time Prepared: 11/22/2022 12:05 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	5.00	ADMINISTRATIVE & GENERAL	TO OFFSET MANAGEMENT FEES	0	1,788,544	1.00
2.00	1.00	CAP REL COSTS-BLDG & FIXT	TO INCLUDE ALLOWABLE HOME OF	55,398	0	2.00
3.00	1.00	CAP REL COSTS-BLDG & FIXT	TO INCLUDE ALLOWABLE HOME OF	148,778	0	3.00
3.01	5.00	ADMINISTRATIVE & GENERAL	TO INCLUDE ALLOWABLE HOME OF	1,178,640	0	3.01
3.02	5.00	ADMINISTRATIVE & GENERAL	TO INCLUDE ALLOWABLE HOME OF	127,954	0	3.02
3.03	2.00	CAP REL COSTS-MVBLE EQUIP	INTERCOMPANY WAGE AND EXPENS	6,182	6,182	3.03
3.04	3.00	OTHER CAP REL COSTS	INTERCOMPANY WAGE AND EXPENS	27,764	27,764	3.04
3.05	4.00	EMPLOYEE BENEFITS DEPARTMENT	INTERCOMPANY WAGE AND EXPENS	1,609,464	1,609,464	3.05
3.06	5.00	ADMINISTRATIVE & GENERAL	INTERCOMPANY WAGE AND EXPENS	2,245,634	2,245,634	3.06
3.07	7.00	OPERATION OF PLANT	INTERCOMPANY WAGE AND EXPENS	11,684	11,684	3.07
3.08	8.00	LAUNDRY & LINEN SERVICE	INTERCOMPANY WAGE AND EXPENS	171	171	3.08
3.09	9.00	HOUSEKEEPING	INTERCOMPANY WAGE AND EXPENS	698	698	3.09
3.10	10.00	DIETARY	INTERCOMPANY WAGE AND EXPENS	-7,875	-7,875	3.10
3.11	13.00	NURSING ADMINISTRATION	INTERCOMPANY WAGE AND EXPENS	5,430	5,430	3.11
3.12	17.00	SOCIAL SERVICE	INTERCOMPANY WAGE AND EXPENS	7,592	7,592	3.12
3.13	30.00	ADULTS & PEDIATRICS	INTERCOMPANY WAGE AND EXPENS	22,120	22,120	3.13
3.14	54.00	RADIOLOGY-DIAGNOSTIC	INTERCOMPANY WAGE AND EXPENS	-129	-129	3.14
3.15	60.00	LABORATORY	INTERCOMPANY WAGE AND EXPENS	279	279	3.15
3.16	65.00	RESPIRATORY THERAPY	INTERCOMPANY WAGE AND EXPENS	24	24	3.16
3.17	66.00	PHYSICAL THERAPY	INTERCOMPANY WAGE AND EXPENS	3,266	3,266	3.17
3.18	67.00	OCCUPATIONAL THERAPY	INTERCOMPANY WAGE AND EXPENS	629	629	3.18
3.19	68.00	SPEECH PATHOLOGY	INTERCOMPANY WAGE AND EXPENS	1,857	1,857	3.19
3.20	71.00	MEDICAL SUPPLIES CHARGED TO	INTERCOMPANY WAGE AND EXPENS	-17,972	-17,972	3.20
3.21	73.00	DRUGS CHARGED TO PATIENTS	INTERCOMPANY WAGE AND EXPENS	341,635	341,635	3.21
3.22	76.01	SPECIAL PROCEDURES	INTERCOMPANY WAGE AND EXPENS	343	343	3.22
3.23	113.00	INTEREST EXPENSE	INTERCOMPANY WAGE AND EXPENS	2,914	2,914	3.23
3.24	1.00	CAP REL COSTS-BLDG & FIXT	RELATED PARTY - DEACONESS	268,029	268,029	3.24
3.25	2.00	CAP REL COSTS-MVBLE EQUIP	RELATED PARTY - DEACONESS	1,249	5,719	3.25
3.26	5.00	ADMINISTRATIVE & GENERAL	RELATED PARTY - DEACONESS	1,536	7,034	3.26
3.27	8.00	LAUNDRY & LINEN SERVICE	RELATED PARTY - DEACONESS	6,604	6,604	3.27
3.28	9.00	HOUSEKEEPING	RELATED PARTY - DEACONESS	325	1,486	3.28
3.29	10.00	DIETARY	RELATED PARTY - DEACONESS	26,211	120,015	3.29
3.30	30.00	ADULTS & PEDIATRICS	RELATED PARTY - DEACONESS	6,127	9,513	3.30
3.31	54.00	RADIOLOGY-DIAGNOSTIC	RELATED PARTY - DEACONESS	0	882	3.31
3.32	54.01	RADIOLOGY - SUA	RELATED PARTY - DEACONESS	25,288	48,995	3.32
3.33	60.00	LABORATORY	RELATED PARTY - DEACONESS	128,396	159,389	3.33
3.34	71.00	MEDICAL SUPPLIES CHARGED TO	RELATED PARTY - DEACONESS	5,188	25,374	3.34
3.35	73.00	DRUGS CHARGED TO PATIENTS	RELATED PARTY - DEACONESS	579	2,696	3.35
3.36	76.02	SPECIAL PROCEDURES - SUA	RELATED PARTY - DEACONESS	41,399	65,273	3.36
3.37	0.00			0	0	3.37
4.00	0.00			0	0	4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			6,283,411	6,771,263	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	Related Organization(s) and/or Home Office: 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		72.50	ENCOMPASS HEALT	0.00	6.00
7.00	B		27.50	DEACONESS HOSPI	0.00	7.00
8.00	G	ENCOMPASS HEALT	0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 15-3025 | Period: From 01/01/2022 To 07/31/2022 | Worksheet A-8-1 | Date/Time Prepared: 11/22/2022 12:05 pm

				Related Organization(s) and/or Home Office		
	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	
	1.00	2.00	3.00	4.00	5.00	
100.00	G. Other (financial or non-financial) specify:	FINANCIAL				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: 15-3025 | Period: From 01/01/2022 To 07/31/2022 | Worksheet A-8-1 | Date/Time Prepared: 11/22/2022 12:05 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	-1,788,544	0	1.00
2.00	55,398	9	2.00
3.00	148,778	11	3.00
3.01	1,178,640	0	3.01
3.02	127,954	0	3.02
3.03	0	9	3.03
3.04	0	9	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	0	0	3.12
3.13	0	0	3.13
3.14	0	0	3.14
3.15	0	0	3.15
3.16	0	0	3.16
3.17	0	0	3.17
3.18	0	0	3.18
3.19	0	0	3.19
3.20	0	0	3.20
3.21	0	0	3.21
3.22	0	0	3.22
3.23	0	11	3.23
3.24	0	10	3.24
3.25	-4,470	10	3.25
3.26	-5,498	0	3.26
3.27	0	0	3.27
3.28	-1,161	0	3.28
3.29	-93,804	0	3.29
3.30	-3,386	0	3.30
3.31	-882	0	3.31
3.32	-23,707	0	3.32
3.33	-30,993	0	3.33
3.34	-20,186	0	3.34
3.35	-2,117	0	3.35
3.36	-23,874	0	3.36
3.37	0	0	3.37
4.00	0	0	4.00
5.00	-487,852		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.

	Type of Business	
6.00	HEALTHCARE	6.00
7.00	HEALTHCARE	7.00
8.00	HEALTHCARE	8.00
9.00		9.00
10.00		10.00
100.00		100.00

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 15-3025	Period: From 01/01/2022 To 07/31/2022	Worksheet A-8-1 Date/Time Prepared: 11/22/2022 12:05 pm

	Related Organization(s) and/or Home Office	
	Type of Business	
	6.00	

(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: 15-3025 | Period: From 01/01/2022 To 07/31/2022 | Worksheet A-8-2 | Date/Time Prepared: 11/22/2022 12:05 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	30.00	AGGREGATE-ADULTS & PEDIATRICS	17,630	0	17,630	211,500	139	1.00
2.00	0.00		0	0	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			17,630	0	17,630		139	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	14,134	707	0	0	0	1.00
2.00	0.00		0	0	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			14,134	707	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	1.00	2.00	15.00	16.00	17.00	18.00	
1.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	0	14,134	3,496	3,496	1.00
2.00	0.00		0	0	0	0	2.00
3.00	0.00		0	0	0	0	3.00
4.00	0.00		0	0	0	0	4.00
5.00	0.00		0	0	0	0	5.00
6.00	0.00		0	0	0	0	6.00
7.00	0.00		0	0	0	0	7.00
8.00	0.00		0	0	0	0	8.00
9.00	0.00		0	0	0	0	9.00
10.00	0.00		0	0	0	0	10.00
200.00			0	14,134	3,496	3,496	200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-3025 | Period: From 01/01/2022 To 07/31/2022 | Worksheet B Part I | Date/Time Prepared: 11/22/2022 12:05 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	1,430,887	1,430,887				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	586,532		586,532			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,357,867	7,124	2,920	2,367,911		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,278,015	55,718	22,839	299,939	3,656,511	5.00
7.00	00700	OPERATION OF PLANT	613,261	45,734	18,747	41,108	718,850	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	188,556	4,169	1,709	0	194,434	8.00
9.00	00900	HOUSEKEEPING	240,622	8,227	3,372	45,158	297,379	9.00
10.00	01000	DIETARY	568,841	77,890	31,928	68,012	746,671	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	639,768	6,501	2,665	141,318	790,252	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	62,864	5,799	2,377	14,412	85,452	16.00
17.00	01700	SOCIAL SERVICE	404,764	26,853	11,007	90,855	533,479	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,015,816	951,454	390,009	970,116	7,327,395	30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	92,650	0	0	0	92,650	54.00
54.01	05401	RADIOLOGY - SUA	27,992	0	0	0	27,992	54.01
60.00	06000	LABORATORY	425,270	19,185	7,864	0	452,319	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	278,376	5,303	2,174	62,492	348,345	65.00
66.00	06600	PHYSICAL THERAPY	916,796	111,356	45,646	188,081	1,261,879	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,090,805	56,117	23,003	244,047	1,413,972	67.00
68.00	06800	SPEECH PATHOLOGY	349,236	16,358	6,705	78,735	451,034	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	209,959	18,690	7,661	11,123	247,433	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	777,601	11,725	4,806	89,034	883,166	73.00
76.00	03020	PSYCH	0	0	0	0	0	76.00
76.01	03951	SPECIAL PROCEDURES	0	0	0	0	0	76.01
76.02	03950	SPECIAL PROCEDURES - SUA	60,793	0	0	0	60,793	76.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	19,617,271	1,428,203	585,432	2,344,430	19,590,006	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	MARKETING NRCC	105,975	2,684	1,100	23,481	133,240	194.00
194.01	07951	GUEST MEALS	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	19,723,246	1,430,887	586,532	2,367,911	19,723,246	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-3025 | Period: From 01/01/2022 To 07/31/2022 | Worksheet B Part I Date/Time Prepared: 11/22/2022 12:05 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	3,656,511					5.00
7.00	00700	OPERATION OF PLANT	164,507	883,357				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	44,496	2,785	241,715			8.00
9.00	00900	HOUSEKEEPING	68,054	5,496	0	370,929		9.00
10.00	01000	DIETARY	170,873	52,034	0	22,056	991,634	10.00
11.00	01100	CAFETERIA	0	0	0	0	147,518	11.00
13.00	01300	NURSING ADMINISTRATION	180,847	4,343	0	1,841	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	19,555	3,874	0	1,642	0	16.00
17.00	01700	SOCIAL SERVICE	122,085	17,939	0	7,604	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,676,857	635,608	241,715	269,423	823,790	30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	21,203	0	0	0	0	54.00
54.01	05401	RADIOLOGY - SUA	0	0	0	0	0	54.01
60.00	06000	LABORATORY	103,512	12,816	0	5,433	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	79,718	3,543	0	1,502	0	65.00
66.00	06600	PHYSICAL THERAPY	288,777	74,390	0	31,533	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	323,583	37,489	0	15,891	0	67.00
68.00	06800	SPEECH PATHOLOGY	103,218	10,928	0	4,632	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	56,624	12,486	0	5,292	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	202,110	7,833	0	3,320	0	73.00
76.00	03020	PSYCH	0	0	0	0	0	76.00
76.01	03951	SPECIAL PROCEDURES	0	0	0	0	0	76.01
76.02	03950	SPECIAL PROCEDURES - SUA	0	0	0	0	0	76.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,626,019	881,564	241,715	370,169	971,308	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	MARKETING NRCC	30,492	1,793	0	760	0	194.00
194.01	07951	GUEST MEALS	0	0	0	0	20,326	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	3,656,511	883,357	241,715	370,929	991,634	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-3025 | Period: From 01/01/2022 To 07/31/2022 | Worksheet B Part I Date/Time Prepared: 11/22/2022 12:05 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES APPRV	
			11.00	13.00	16.00	17.00	21.00	
		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	147,518					11.00
13.00	01300	NURSING ADMINISTRATION	10,893	988,176				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,111	0	111,634			16.00
17.00	01700	SOCIAL SERVICE	7,003	0	0	688,110		17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0		22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	74,785	988,176	54,456	688,110	0	30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	673	0	0	54.00
54.01	05401	RADIOLOGY - SUA	0	0	0	0	0	54.01
60.00	06000	LABORATORY	0	0	4,404	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	4,817	0	1,587	0	0	65.00
66.00	06600	PHYSICAL THERAPY	14,498	0	15,277	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	18,812	0	16,616	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	6,069	0	4,143	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	857	0	1,512	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,863	0	12,966	0	0	73.00
76.00	03020	PSYCH	0	0	0	0	0	76.00
76.01	03951	SPECIAL PROCEDURES	0	0	0	0	0	76.01
76.02	03950	SPECIAL PROCEDURES - SUA	0	0	0	0	0	76.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	145,708	988,176	111,634	688,110	0	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	MARKETING NRCC	1,810	0	0	0	0	194.00
194.01	07951	GUEST MEALS	0	0	0	0	0	194.01
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)	147,518	988,176	111,634	688,110	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-3025 | Period: From 01/01/2022 To 07/31/2022 | Worksheet B Part I | Date/Time Prepared: 11/22/2022 12:05 pm

		Cost Center Description	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS APPRV	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			22.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV						21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0					22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	12,780,315	0	12,780,315		30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	114,526	0	114,526		54.00
54.01	05401	RADIOLOGY - SUA	0	27,992	0	27,992		54.01
60.00	06000	LABORATORY	0	578,484	0	578,484		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0		62.30
65.00	06500	RESPIRATORY THERAPY	0	439,512	0	439,512		65.00
66.00	06600	PHYSICAL THERAPY	0	1,686,354	0	1,686,354		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,826,363	0	1,826,363		67.00
68.00	06800	SPEECH PATHOLOGY	0	580,024	0	580,024		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	324,204	0	324,204		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,116,258	0	1,116,258		73.00
76.00	03020	PSYCH	0	0	0	0		76.00
76.01	03951	SPECIAL PROCEDURES	0	0	0	0		76.01
76.02	03950	SPECIAL PROCEDURES - SUA	0	60,793	0	60,793		76.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0		76.98
76.99	07699	LITHOTRIPSY	0	0	0	0		76.99
		OUTPATIENT SERVICE COST CENTERS						
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0			92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0		93.99
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	19,534,825	0	19,534,825		118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	MARKETING NRCC	0	168,095	0	168,095		194.00
194.01	07951	GUEST MEALS	0	20,326	0	20,326		194.01
200.00		Cross Foot Adjustments	0	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	0	19,723,246	0	19,723,246		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-3025 | Period: From 01/01/2022 To 07/31/2022 | Worksheet B Part II Date/Time Prepared: 11/22/2022 12:05 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
				BLDG & FIXT	MVBLE EQUIP			
			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	7,124	2,920	10,044	10,044	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	55,718	22,839	78,557	1,272	5.00
7.00	00700	OPERATION OF PLANT	0	45,734	18,747	64,481	174	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	4,169	1,709	5,878	0	8.00
9.00	00900	HOUSEKEEPING	0	8,227	3,372	11,599	191	9.00
10.00	01000	DIETARY	0	77,890	31,928	109,818	288	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	6,501	2,665	9,166	599	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	5,799	2,377	8,176	61	16.00
17.00	01700	SOCIAL SERVICE	0	26,853	11,007	37,860	385	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	951,454	390,009	1,341,463	4,118	30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	RADIOLOGY - SUA	0	0	0	0	0	54.01
60.00	06000	LABORATORY	0	19,185	7,864	27,049	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	5,303	2,174	7,477	265	65.00
66.00	06600	PHYSICAL THERAPY	0	111,356	45,646	157,002	797	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	56,117	23,003	79,120	1,035	67.00
68.00	06800	SPEECH PATHOLOGY	0	16,358	6,705	23,063	334	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	18,690	7,661	26,351	47	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	11,725	4,806	16,531	378	73.00
76.00	03020	PSYCH	0	0	0	0	0	76.00
76.01	03951	SPECIAL PROCEDURES	0	0	0	0	0	76.01
76.02	03950	SPECIAL PROCEDURES - SUA	0	0	0	0	0	76.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	1,428,203	585,432	2,013,635	9,944	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	MARKETING NRCC	0	2,684	1,100	3,784	100	194.00
194.01	07951	GUEST MEALS	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	1,430,887	586,532	2,017,419	10,044	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-3025 | Period: From 01/01/2022 To 07/31/2022 | Worksheet B Part II | Date/Time Prepared: 11/22/2022 12:05 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	79,829					5.00
7.00	00700	OPERATION OF PLANT	3,591	68,246				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	971	215	7,064			8.00
9.00	00900	HOUSEKEEPING	1,486	425	0	13,701		9.00
10.00	01000	DIETARY	3,730	4,020	0	815	118,671	10.00
11.00	01100	CAFETERIA	0	0	0	0	17,654	11.00
13.00	01300	NURSING ADMINISTRATION	3,948	336	0	68	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	427	299	0	61	0	16.00
17.00	01700	SOCIAL SERVICE	2,665	1,386	0	281	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	36,613	49,105	7,064	9,951	98,585	30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	463	0	0	0	0	54.00
54.01	05401	RADIOLOGY - SUA	0	0	0	0	0	54.01
60.00	06000	LABORATORY	2,260	990	0	201	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	1,740	274	0	55	0	65.00
66.00	06600	PHYSICAL THERAPY	6,304	5,747	0	1,165	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	7,064	2,896	0	587	0	67.00
68.00	06800	SPEECH PATHOLOGY	2,253	844	0	171	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,236	965	0	195	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,412	605	0	123	0	73.00
76.00	03020	PSYCH	0	0	0	0	0	76.00
76.01	03951	SPECIAL PROCEDURES	0	0	0	0	0	76.01
76.02	03950	SPECIAL PROCEDURES - SUA	0	0	0	0	0	76.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	79,163	68,107	7,064	13,673	116,239	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	MARKETING NRCC	666	139	0	28	0	194.00
194.01	07951	GUEST MEALS	0	0	0	0	2,432	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	79,829	68,246	7,064	13,701	118,671	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-3025 | Period: From 01/01/2022 To 07/31/2022 | Worksheet B Part II Date/Time Prepared: 11/22/2022 12:05 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES APPRV	
			11.00	13.00	16.00	17.00	21.00	
		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	17,654					11.00
13.00	01300	NURSING ADMINISTRATION	1,304	15,421				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	133	0	9,157			16.00
17.00	01700	SOCIAL SERVICE	838	0	0	43,415		17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0		22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,950	15,421	4,464	43,415		30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	55	0		54.00
54.01	05401	RADIOLOGY - SUA	0	0	0	0		54.01
60.00	06000	LABORATORY	0	0	362	0		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0		62.30
65.00	06500	RESPIRATORY THERAPY	576	0	130	0		65.00
66.00	06600	PHYSICAL THERAPY	1,735	0	1,254	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	2,251	0	1,364	0		67.00
68.00	06800	SPEECH PATHOLOGY	726	0	340	0		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	103	0	124	0		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	821	0	1,064	0		73.00
76.00	03020	PSYCH	0	0	0	0		76.00
76.01	03951	SPECIAL PROCEDURES	0	0	0	0		76.01
76.02	03950	SPECIAL PROCEDURES - SUA	0	0	0	0		76.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0		76.98
76.99	07699	LITHOTRIPSY	0	0	0	0		76.99
		OUTPATIENT SERVICE COST CENTERS						
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0		93.99
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	17,437	15,421	9,157	43,415	0	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	MARKETING NRCC	217	0	0	0		194.00
194.01	07951	GUEST MEALS	0	0	0	0		194.01
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)	17,654	15,421	9,157	43,415	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-3025 | Period: From 01/01/2022 To 07/31/2022 | Worksheet B Part II | Date/Time Prepared: 11/22/2022 12:05 pm

		Cost Center Description	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS APPRV	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			22.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV						21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0					22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS		1,619,149	0	1,619,149		30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC		518	0	518		54.00
54.01	05401	RADIOLOGY - SUA		0	0	0		54.01
60.00	06000	LABORATORY		30,862	0	30,862		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS		0	0	0		62.30
65.00	06500	RESPIRATORY THERAPY		10,517	0	10,517		65.00
66.00	06600	PHYSICAL THERAPY		174,004	0	174,004		66.00
67.00	06700	OCCUPATIONAL THERAPY		94,317	0	94,317		67.00
68.00	06800	SPEECH PATHOLOGY		27,731	0	27,731		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		29,021	0	29,021		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS		23,934	0	23,934		73.00
76.00	03020	PSYCH		0	0	0		76.00
76.01	03951	SPECIAL PROCEDURES		0	0	0		76.01
76.02	03950	SPECIAL PROCEDURES - SUA		0	0	0		76.02
76.97	07697	CARDIAC REHABILITATION		0	0	0		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY		0	0	0		76.98
76.99	07699	LITHOTRIPSY		0	0	0		76.99
		OUTPATIENT SERVICE COST CENTERS						
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0			92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM		0	0	0		93.99
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	2,010,053	0	2,010,053		118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	MARKETING NRCC		4,934	0	4,934		194.00
194.01	07951	GUEST MEALS		2,432	0	2,432		194.01
200.00		Cross Foot Adjustments	0	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	0	2,017,419	0	2,017,419		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-3025 | Period: From 01/01/2022 To 07/31/2022 | Worksheet B-1 | Date/Time Prepared: 11/22/2022 12:05 pm

		Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM COST)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	89,575					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		89,575				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	446	446	10,361,509			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,488	3,488	1,312,472	-3,656,511	15,977,950	5.00
7.00	00700	OPERATION OF PLANT	2,863	2,863	179,881	0	718,850	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	261	261	0	0	194,434	8.00
9.00	00900	HOUSEKEEPING	515	515	197,603	0	297,379	9.00
10.00	01000	DIETARY	4,876	4,876	297,608	0	746,671	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	407	407	618,377	0	790,252	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	363	363	63,064	0	85,452	16.00
17.00	01700	SOCIAL SERVICE	1,681	1,681	397,561	0	533,479	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	59,562	59,562	4,245,043	0	7,327,395	30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	92,650	54.00
54.01	05401	RADIOLOGY - SUA	0	0	0	-27,992	0	54.01
60.00	06000	LABORATORY	1,201	1,201	0	0	452,319	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	332	332	273,454	0	348,345	65.00
66.00	06600	PHYSICAL THERAPY	6,971	6,971	823,002	0	1,261,879	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,513	3,513	1,067,900	0	1,413,972	67.00
68.00	06800	SPEECH PATHOLOGY	1,024	1,024	344,529	0	451,034	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,170	1,170	48,674	0	247,433	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	734	734	389,594	0	883,166	73.00
76.00	03020	PSYCH	0	0	0	0	0	76.00
76.01	03951	SPECIAL PROCEDURES	0	0	0	0	0	76.01
76.02	03950	SPECIAL PROCEDURES - SUA	0	0	0	-60,793	0	76.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	89,407	89,407	10,258,762	-3,745,296	15,844,710	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	MARKETING NRCC	168	168	102,747	0	133,240	194.00
194.01	07951	GUEST MEALS	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,430,887	586,532	2,367,911		3,656,511	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	15.974178	6.547943	0.228530		0.228847	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			10,044		79,829	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000969		0.004996	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: 15-3025 | Period: From 01/01/2022 To 07/31/2022 | Worksheet B-1 | Date/Time Prepared: 11/22/2022 12:05 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (TOTAL PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (GROSS SALARIES)	
			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	82,778					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	261	19,359				8.00
9.00	00900	HOUSEKEEPING	515	0	82,002			9.00
10.00	01000	DIETARY	4,876	0	4,876	69,910		10.00
11.00	01100	CAFETERIA	0	0	0	10,400	8,373,945	11.00
13.00	01300	NURSING ADMINISTRATION	407	0	407	0	618,377	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	363	0	363	0	63,064	16.00
17.00	01700	SOCIAL SERVICE	1,681	0	1,681	0	397,561	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	59,562	19,359	59,562	58,077	4,245,043	30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	RADIOLOGY - SUA	0	0	0	0	0	54.01
60.00	06000	LABORATORY	1,201	0	1,201	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	332	0	332	0	273,454	65.00
66.00	06600	PHYSICAL THERAPY	6,971	0	6,971	0	823,002	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,513	0	3,513	0	1,067,900	67.00
68.00	06800	SPEECH PATHOLOGY	1,024	0	1,024	0	344,529	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,170	0	1,170	0	48,674	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	734	0	734	0	389,594	73.00
76.00	03020	PSYCH	0	0	0	0	0	76.00
76.01	03951	SPECIAL PROCEDURES	0	0	0	0	0	76.01
76.02	03950	SPECIAL PROCEDURES - SUA	0	0	0	0	0	76.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	82,610	19,359	81,834	68,477	8,271,198	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	MARKETING NRCC	168	0	168	0	102,747	194.00
194.01	07951	GUEST MEALS	0	0	0	1,433	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	883,357	241,715	370,929	991,634	147,518	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	10.671398	12.485924	4.523414	14.184437	0.017616	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	68,246	7,064	13,701	118,671	17,654	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.824446	0.364895	0.167081	1.697482	0.002108	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: 15-3025 | Period: From 01/01/2022 To 07/31/2022 | Worksheet B-1 | Date/Time Prepared: 11/22/2022 12:05 pm

		Cost Center Description	NURSING ADMINISTRATION (TOTAL PATIENT DAYS)	MEDICAL RECORDS & LIBRARY (GROSS REV MED REC)	SOCIAL SERVICE (TOTAL PATIENT DAYS)	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES APPRV (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS APPRV (ASSIGNED TIME)	
			13.00	16.00	17.00	21.00	22.00	
		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	19,359					13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	42,433,793				16.00
17.00	01700	SOCIAL SERVICE	0	0	19,359			17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0		21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0		0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	19,359	20,701,570	19,359	0	0	30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	255,682	0	0	0	54.00
54.01	05401	RADIOLOGY - SUA	0	0	0	0	0	54.01
60.00	06000	LABORATORY	0	1,673,840	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	603,360	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	5,806,390	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	6,315,444	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,574,661	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	574,633	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	4,928,213	0	0	0	73.00
76.00	03020	PSYCH	0	0	0	0	0	76.00
76.01	03951	SPECIAL PROCEDURES	0	0	0	0	0	76.01
76.02	03950	SPECIAL PROCEDURES - SUA	0	0	0	0	0	76.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	19,359	42,433,793	19,359	0	0	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	MARKETING NRCC	0	0	0	0	0	194.00
194.01	07951	GUEST MEALS	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	988,176	111,634	688,110	0	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	51.044785	0.002631	35.544708	0.000000	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	15,421	9,157	43,415	0	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.796580	0.000216	2.242626	0.000000	0.000000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-3025 | Period: From 01/01/2022 To 07/31/2022 | Worksheet C Part I | Date/Time Prepared: 11/22/2022 12:05 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs: Total Costs	Costs: RCE Disallowance	Costs: Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	12,780,315		12,780,315	3,496	12,783,811	30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	114,526		114,526	0	114,526	54.00
54.01	05401	RADIOLOGY - SUA	27,992		27,992	0	27,992	54.01
60.00	06000	LABORATORY	578,484		578,484	0	578,484	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	439,512	0	439,512	0	439,512	65.00
66.00	06600	PHYSICAL THERAPY	1,686,354	0	1,686,354	0	1,686,354	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,826,363	0	1,826,363	0	1,826,363	67.00
68.00	06800	SPEECH PATHOLOGY	580,024	0	580,024	0	580,024	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	324,204		324,204	0	324,204	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,116,258		1,116,258	0	1,116,258	73.00
76.00	03020	PSYCH	0		0	0	0	76.00
76.01	03951	SPECIAL PROCEDURES	0		0	0	0	76.01
76.02	03950	SPECIAL PROCEDURES - SUA	60,793		60,793	0	60,793	76.02
76.97	07697	CARDIAC REHABILITATION	0		0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0		0	0	0	76.98
76.99	07699	LITHOTRIPSY	0		0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0		0	0	0	93.99
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	19,534,825	0	19,534,825	3,496	19,538,321	200.00
201.00		Less Observation Beds	0		0		0	201.00
202.00		Total (see instructions)	19,534,825	0	19,534,825	3,496	19,538,321	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-3025

Period: From 01/01/2022 To 07/31/2022

Worksheet C Part I

Date/Time Prepared: 11/22/2022 12:05 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	20,701,570		20,701,570			30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	254,968	714	255,682	0.447924	0.000000	54.00
54.01	05401	RADIOLOGY - SUA	134,839	0	134,839	0.207596	0.000000	54.01
60.00	06000	LABORATORY	1,673,840	0	1,673,840	0.345603	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	603,360	0	603,360	0.728441	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	5,806,390	0	5,806,390	0.290431	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	6,315,444	0	6,315,444	0.289190	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	1,574,661	0	1,574,661	0.368348	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	574,633	0	574,633	0.564193	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,928,213	0	4,928,213	0.226504	0.000000	73.00
76.00	03020	PSYCH	0	0	0	0.000000	0.000000	76.00
76.01	03951	SPECIAL PROCEDURES	0	0	0	0.000000	0.000000	76.01
76.02	03950	SPECIAL PROCEDURES - SUA	176,437	0	176,437	0.344559	0.000000	76.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	0.000000	76.99
		OUTPATIENT SERVICE COST CENTERS						
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0.000000	0.000000	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0.000000	0.000000	93.99
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	42,744,355	714	42,745,069			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	42,744,355	714	42,745,069			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-3025 | Period: From 01/01/2022 To 07/31/2022 | Worksheet C Part I | Date/Time Prepared: 11/22/2022 12:05 pm

Title XVIII | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
		ANCILLARY SERVICE COST CENTERS		
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.447924	54.00
54.01	05401	RADIOLOGY - SUA	0.207596	54.01
60.00	06000	LABORATORY	0.345603	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	0.728441	65.00
66.00	06600	PHYSICAL THERAPY	0.290431	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.289190	67.00
68.00	06800	SPEECH PATHOLOGY	0.368348	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.564193	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.226504	73.00
76.00	03020	PSYCH	0.000000	76.00
76.01	03951	SPECIAL PROCEDURES	0.000000	76.01
76.02	03950	SPECIAL PROCEDURES - SUA	0.344559	76.02
76.97	07697	CARDIAC REHABILITATION	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	76.98
76.99	07699	LITHOTRIPSY	0.000000	76.99
		OUTPATIENT SERVICE COST CENTERS		
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.000000	93.99
		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: 15-3025 | Period: From 01/01/2022 To 07/31/2022 | Worksheet C Part I | Date/Time Prepared: 11/22/2022 12:05 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs: Total Costs	Costs: RCE Disallowance	Costs: Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	12,780,315		12,780,315	3,496	12,783,811	30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	114,526		114,526	0	114,526	54.00
54.01	05401	RADIOLOGY - SUA	27,992		27,992	0	27,992	54.01
60.00	06000	LABORATORY	578,484		578,484	0	578,484	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	439,512	0	439,512	0	439,512	65.00
66.00	06600	PHYSICAL THERAPY	1,686,354	0	1,686,354	0	1,686,354	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,826,363	0	1,826,363	0	1,826,363	67.00
68.00	06800	SPEECH PATHOLOGY	580,024	0	580,024	0	580,024	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	324,204		324,204	0	324,204	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,116,258		1,116,258	0	1,116,258	73.00
76.00	03020	PSYCH	0		0	0	0	76.00
76.01	03951	SPECIAL PROCEDURES	0		0	0	0	76.01
76.02	03950	SPECIAL PROCEDURES - SUA	60,793		60,793	0	60,793	76.02
76.97	07697	CARDIAC REHABILITATION	0		0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0		0	0	0	76.98
76.99	07699	LITHOTRIPSY	0		0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0		0	0	0	93.99
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	19,534,825	0	19,534,825	3,496	19,538,321	200.00
201.00		Less Observation Beds	0		0		0	201.00
202.00		Total (see instructions)	19,534,825	0	19,534,825	3,496	19,538,321	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-3025 | Period: From 01/01/2022 To 07/31/2022 | Worksheet C Part I Date/Time Prepared: 11/22/2022 12:05 pm

Title XIX | Hospital | Cost

		Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	20,701,570		20,701,570			30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	254,968	714	255,682	0.447924	0.000000	54.00
54.01	05401	RADIOLOGY - SUA	134,839	0	134,839	0.207596	0.000000	54.01
60.00	06000	LABORATORY	1,673,840	0	1,673,840	0.345603	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	603,360	0	603,360	0.728441	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	5,806,390	0	5,806,390	0.290431	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	6,315,444	0	6,315,444	0.289190	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	1,574,661	0	1,574,661	0.368348	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	574,633	0	574,633	0.564193	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,928,213	0	4,928,213	0.226504	0.000000	73.00
76.00	03020	PSYCH	0	0	0	0.000000	0.000000	76.00
76.01	03951	SPECIAL PROCEDURES	0	0	0	0.000000	0.000000	76.01
76.02	03950	SPECIAL PROCEDURES - SUA	176,437	0	176,437	0.344559	0.000000	76.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	0.000000	76.99
		OUTPATIENT SERVICE COST CENTERS						
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0.000000	0.000000	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0.000000	0.000000	93.99
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	42,744,355	714	42,745,069			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	42,744,355	714	42,745,069			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-3025 | Period: From 01/01/2022 To 07/31/2022 | Worksheet C Part I Date/Time Prepared: 11/22/2022 12:05 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
		ANCILLARY SERVICE COST CENTERS		
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
54.01	05401	RADIOLOGY - SUA	0.000000	54.01
60.00	06000	LABORATORY	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	62.30
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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
76.00	03020	PSYCH	0.000000	76.00
76.01	03951	SPECIAL PROCEDURES	0.000000	76.01
76.02	03950	SPECIAL PROCEDURES - SUA	0.000000	76.02
76.97	07697	CARDIAC REHABILITATION	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	76.98
76.99	07699	LITHOTRIPSY	0.000000	76.99
		OUTPATIENT SERVICE COST CENTERS		
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.000000	93.99
		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: 15-3025 | Period: From 01/01/2022 To 07/31/2022 | Worksheet D Part I Date/Time Prepared: 11/22/2022 12:05 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	1,619,149	0	1,619,149	19,359	83.64	30.00
200.00	Total (lines 30 through 199)	1,619,149		1,619,149	19,359		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	9,459	791,151	30.00
200.00	Total (lines 30 through 199)	9,459	791,151	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 15-3025

Period: From 01/01/2022 To 07/31/2022

Worksheet D Part II

Date/Time Prepared: 11/22/2022 12:05 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						
54.00	05400	RADIOLOGY-DIAGNOSTIC	518	255,682	0.002026	147,994	300	54.00
54.01	05401	RADIOLOGY - SUA	0	134,839	0.000000	78,051	0	54.01
60.00	06000	LABORATORY	30,862	1,673,840	0.018438	955,685	17,621	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	10,517	603,360	0.017431	324,806	5,662	65.00
66.00	06600	PHYSICAL THERAPY	174,004	5,806,390	0.029968	2,865,560	85,875	66.00
67.00	06700	OCCUPATIONAL THERAPY	94,317	6,315,444	0.014934	3,151,472	47,064	67.00
68.00	06800	SPEECH PATHOLOGY	27,731	1,574,661	0.017611	712,927	12,555	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	29,021	574,633	0.050504	318,876	16,105	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	23,934	4,928,213	0.004857	2,427,811	11,792	73.00
76.00	03020	PSYCH	0	0	0.000000	0	0	76.00
76.01	03951	SPECIAL PROCEDURES	0	0	0.000000	0	0	76.01
76.02	03950	SPECIAL PROCEDURES - SUA	0	176,437	0.000000	23,016	0	76.02
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0.000000	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0.000000	0	0	93.99
200.00		Total (lines 50 through 199)	390,904	22,043,499		11,006,198	196,974	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-3025 | Period: From 01/01/2022 To 07/31/2022 | Worksheet D Part III Date/Time Prepared: 11/22/2022 12:05 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
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	19,359	0.00	9,459	30.00
200.00		Total (lines 30 through 199)		0	19,359		9,459	200.00

		Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
			9.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	0	30.00
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-3025

Period: From 01/01/2022 To 07/31/2022

Worksheet D Part IV

Date/Time Prepared: 11/22/2022 12:05 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						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	RADIOLOGY - SUA	0	0	0	0	0	54.01
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	PSYCH	0	0	0	0	0	76.00
76.01	03951	SPECIAL PROCEDURES	0	0	0	0	0	76.01
76.02	03950	SPECIAL PROCEDURES - SUA	0	0	0	0	0	76.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-3025 | Period: From 01/01/2022 To 07/31/2022 | Worksheet D Part IV | Date/Time Prepared: 11/22/2022 12:05 pm

Title XVIII | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	255,682	0.000000	54.00
54.01	05401	RADIOLOGY - SUA	0	0	0	134,839	0.000000	54.01
60.00	06000	LABORATORY	0	0	0	1,673,840	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	603,360	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	5,806,390	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	6,315,444	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	1,574,661	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	574,633	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	4,928,213	0.000000	73.00
76.00	03020	PSYCH	0	0	0	0	0.000000	76.00
76.01	03951	SPECIAL PROCEDURES	0	0	0	0	0.000000	76.01
76.02	03950	SPECIAL PROCEDURES - SUA	0	0	0	176,437	0.000000	76.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0.000000	76.99
		OUTPATIENT SERVICE COST CENTERS						
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0.000000	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0.000000	93.99
200.00		Total (lines 50 through 199)	0	0	0	22,043,499		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-3025 | Period: From 01/01/2022 To 07/31/2022 | Worksheet D Part IV | Date/Time Prepared: 11/22/2022 12:05 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						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	147,994	0	714	0	54.00
54.01	05401	RADIOLOGY - SUA	0.000000	78,051	0	0	0	54.01
60.00	06000	LABORATORY	0.000000	955,685	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.000000	324,806	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	2,865,560	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	3,151,472	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	712,927	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	318,876	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	2,427,811	0	0	0	73.00
76.00	03020	PSYCH	0.000000	0	0	0	0	76.00
76.01	03951	SPECIAL PROCEDURES	0.000000	0	0	0	0	76.01
76.02	03950	SPECIAL PROCEDURES - SUA	0.000000	23,016	0	0	0	76.02
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.000000	0	0	0	0	93.99
200.00		Total (lines 50 through 199)		11,006,198	0	714	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-3025 | Period: From 01/01/2022 To 07/31/2022 | Worksheet D Part V Date/Time Prepared: 11/22/2022 12:05 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						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.447924	714	0	0	320	54.00
54.01	05401	RADIOLOGY - SUA	0.207596	0	0	0	0	54.01
60.00	06000	LABORATORY	0.345603	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.728441	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.290431	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.289190	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.368348	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.564193	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.226504	0	0	0	0	73.00
76.00	03020	PSYCH	0.000000	0	0	0	0	76.00
76.01	03951	SPECIAL PROCEDURES	0.000000	0	0	0	0	76.01
76.02	03950	SPECIAL PROCEDURES - SUA	0.344559	0	0	0	0	76.02
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.000000	0	0	0	0	93.99
200.00		Subtotal (see instructions)		714	0	0	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)		714	0	0	320	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-3025 | Period: From 01/01/2022 To 07/31/2022 | Worksheet D Part V Date/Time Prepared: 11/22/2022 12:05 pm

Title XVIII | Hospital | PPS

		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			
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
54.01	05401	RADIOLOGY - SUA	0	0	54.01
60.00	06000	LABORATORY	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30
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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
76.00	03020	PSYCH	0	0	76.00
76.01	03951	SPECIAL PROCEDURES	0	0	76.01
76.02	03950	SPECIAL PROCEDURES - SUA	0	0	76.02
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS			
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	93.99
200.00		Subtotal (see instructions)	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	0	0	202.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-3025	Period: From 01/01/2022 To 07/31/2022	Worksheet D-1 Date/Time Prepared: 11/22/2022 12:05 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)	19,359	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	19,359	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)	19,359	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)	9,459	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)	12,783,811	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)	12,783,811	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)	12,783,811	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)	660.35	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	6,246,251	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)	6,246,251	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-3025 | Period: From 01/01/2022 To 07/31/2022 | Worksheet D-1 | Date/Time Prepared: 11/22/2022 12:05 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)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	3,393,356	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	9,639,607	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)	791,151	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	196,974	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	988,125	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	8,651,482	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: 15-3025 | Period: From 01/01/2022 To 07/31/2022 | Worksheet D-1 Date/Time Prepared: 11/22/2022 12:05 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	1,619,149	12,783,811	0.126656	0	0	90.00
91.00	Nursing Program cost	0	12,783,811	0.000000	0	0	91.00
92.00	Allied health cost	0	12,783,811	0.000000	0	0	92.00
93.00	All other Medical Education	0	12,783,811	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-3025 | Period: From 01/01/2022 To 07/31/2022 | Worksheet D-1 | Date/Time Prepared: 11/22/2022 12:05 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)	19,359	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	19,359	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)	19,359	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)	170	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)	12,780,315	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)	12,780,315	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)	12,780,315	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)	660.17	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	112,229	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)	112,229	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-3025 | Period: From 01/01/2022 To 07/31/2022 | Worksheet D-1 | Date/Time Prepared: 11/22/2022 12:05 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)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	60,747	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	172,976	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: 15-3025 | Period: From 01/01/2022 To 07/31/2022 | Worksheet D-1 | Date/Time Prepared: 11/22/2022 12:05 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	1,619,149	12,780,315	0.126691	0	0	90.00
91.00	Nursing Program cost	0	12,780,315	0.000000	0	0	91.00
92.00	Allied health cost	0	12,780,315	0.000000	0	0	92.00
93.00	All other Medical Education	0	12,780,315	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-3025 | Period: From 01/01/2022 To 07/31/2022 | Worksheet D-3 | Date/Time Prepared: 11/22/2022 12:05 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		10,103,793		30.00
		ANCILLARY SERVICE COST CENTERS				
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.447924	147,994	66,290	54.00
54.01	05401	RADIOLOGY - SUA	0.207596	78,051	16,203	54.01
60.00	06000	LABORATORY	0.345603	955,685	330,288	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.728441	324,806	236,602	65.00
66.00	06600	PHYSICAL THERAPY	0.290431	2,865,560	832,247	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.289190	3,151,472	911,374	67.00
68.00	06800	SPEECH PATHOLOGY	0.368348	712,927	262,605	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.564193	318,876	179,908	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.226504	2,427,811	549,909	73.00
76.00	03020	PSYCH	0.000000	0	0	76.00
76.01	03951	SPECIAL PROCEDURES	0.000000	0	0	76.01
76.02	03950	SPECIAL PROCEDURES - SUA	0.344559	23,016	7,930	76.02
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS				
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.000000	0	0	93.99
200.00		Total (sum of lines 50 through 94 and 96 through 98)		11,006,198	3,393,356	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)		11,006,198		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-3025 | Period: From 01/01/2022 To 07/31/2022 | Worksheet D-3 | Date/Time Prepared: 11/22/2022 12:05 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		182,070		30.00
		ANCILLARY SERVICE COST CENTERS				
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.447924	1,930	864	54.00
54.01	05401	RADIOLOGY - SUA	0.207596	0	0	54.01
60.00	06000	LABORATORY	0.345603	5,611	1,939	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.728441	7,687	5,600	65.00
66.00	06600	PHYSICAL THERAPY	0.290431	54,822	15,922	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.289190	56,008	16,197	67.00
68.00	06800	SPEECH PATHOLOGY	0.368348	11,119	4,096	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.564193	7,829	4,417	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.226504	51,706	11,712	73.00
76.00	03020	PSYCH	0.000000	0	0	76.00
76.01	03951	SPECIAL PROCEDURES	0.000000	0	0	76.01
76.02	03950	SPECIAL PROCEDURES - SUA	0.344559	0	0	76.02
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS				
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.000000	0	0	93.99
200.00		Total (sum of lines 50 through 94 and 96 through 98)		196,712	60,747	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)		196,712		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-3025 | Period: From 01/01/2022 To 07/31/2022 | Worksheet E Part B Date/Time Prepared: 11/22/2022 12:05 pm

	Title XVIII	Hospital	PPS	
			1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			
1.00	Medical and other services (see instructions)		0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		320	2.00
3.00	OPPS payments		474	3.00
4.00	Outlier payment (see instructions)		0	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		0	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable charges			
12.00	Ancillary service charges		0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		0	14.00
	Customary charges			
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (see instructions)		0	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)		474	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)		95	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)		379	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)		379	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		379	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)			
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00
37.00	Subtotal (see instructions)		379	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)		379	40.00
40.01	Sequestration adjustment (see instructions)		3	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		379	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)		-3	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: 15-3025	Period: From 01/01/2022 To 07/31/2022	Worksheet E Part B Date/Time Prepared: 11/22/2022 12:05 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: 15-3025 | Period: From 01/01/2022 To 07/31/2022 | Worksheet E-1 Part I | Date/Time Prepared: 11/22/2022 12:05 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		16,351,219		379	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)		16,351,219		379	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		56,075		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		3	6.02
7.00	Total Medicare program liability (see instructions)		16,407,294		376	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: 15-3025	Period: From 01/01/2022 To 07/31/2022	Worksheet E-1 Part II Date/Time Prepared: 11/22/2022 12:05 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: 15-3025 | Period: From 01/01/2022 To 07/31/2022 | Worksheet E-3 Part III Date/Time Prepared: 11/22/2022 12:05 pm

Title XVIII | Hospital | PPS

		1.00	
	PART III - MEDICARE PART A SERVICES - IRF PPS		
1.00	Net Federal PPS Payment (see instructions)	15,965,874	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)	0.0437	2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)	860,561	3.00
4.00	Outlier Payments	11,148	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)	91.316038	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)	16,837,583	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)	16,837,583	17.00
18.00	Primary payer payments	10,500	18.00
19.00	Subtotal (line 17 less line 18).	16,827,083	19.00
20.00	Deductibles	241,834	20.00
21.00	Subtotal (line 19 minus line 20)	16,585,249	21.00
22.00	Coinsurance	120,266	22.00
23.00	Subtotal (line 21 minus line 22)	16,464,983	23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	94,308	24.00
25.00	Adjusted reimbursable bad debts (see instructions)	61,300	25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	67,077	26.00
27.00	Subtotal (sum of lines 23 and 25)	16,526,283	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)	0	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)	16,526,283	32.00
32.01	Sequestration adjustment (see instructions)	118,989	32.01
32.02	Demonstration payment adjustment amount after sequestration	0	32.02
33.00	Interim payments	16,351,219	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)	56,075	35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	494,400	36.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4	11,148	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: 15-3025 | Period: From 01/01/2022 To 07/31/2022 | Worksheet E-3 Part VII Date/Time Prepared: 11/22/2022 12:05 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	172,976		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)	172,976	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)	172,976	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	182,070		8.00
9.00	Ancillary service charges	196,712	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)	378,782	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)	378,782	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	205,806	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)	172,976	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)	172,976	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)	172,976	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)	172,976	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	172,976	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)	172,976	0	40.00
41.00	Interim payments	114,114	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	58,862	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: 15-3025 | Period: From 01/01/2022 To 07/31/2022 | Worksheet G | Date/Time Prepared: 11/22/2022 12:05 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	6,957,691	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	10,843,463	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-3,450,212	0	0	0	6.00
7.00	Inventory	40,047	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	25,859	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	14,416,848	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	1,675,024	0	0	0	12.00
13.00	Land improvements	356,682	0	0	0	13.00
14.00	Accumulated depreciation	-15,465,822	0	0	0	14.00
15.00	Buildings	25,009,870	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	1,757,768	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	5,664,844	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	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	18,998,366	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	810,450	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	20,040,816	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	20,851,266	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	54,266,480	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	587,989	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,433,667	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	4,338,430	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	0	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	6,360,086	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	13,806,868	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	13,806,868	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	20,166,954	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	34,099,526				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)	34,099,526	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	54,266,480	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-3025 | Period: From 01/01/2022 To 07/31/2022 | Worksheet G-1 Date/Time Prepared: 11/22/2022 12:05 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		33,783,388		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		9,363,579				2.00
3.00	Total (sum of line 1 and line 2)		43,146,967		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		43,146,967		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00	MINORITY INTEREST EXPENSE	2,574,984		0		0	13.00
14.00	DISTRIBUTIONS	6,472,457		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)		9,047,441		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		34,099,526		0		19.00

		Endowment Fund	Plant Fund		
		6.00	7.00	8.00	
1.00	Fund balances at beginning of period	0		0	1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)				2.00
3.00	Total (sum of line 1 and line 2)	0		0	3.00
4.00	Additions (credit adjustments) (specify)		0		4.00
5.00			0		5.00
6.00			0		6.00
7.00			0		7.00
8.00			0		8.00
9.00			0		9.00
10.00	Total additions (sum of line 4-9)	0		0	10.00
11.00	Subtotal (line 3 plus line 10)	0		0	11.00
12.00	Deductions (debit adjustments) (specify)		0		12.00
13.00	MINORITY INTEREST EXPENSE		0		13.00
14.00	DISTRIBUTIONS		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: 15-3025 | Period: From 01/01/2022 To 07/31/2022 | Worksheet G-2 Parts I & II | Date/Time Prepared: 11/22/2022 12:05 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	20,701,569		20,701,569	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	20,701,569		20,701,569	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	20,701,569		20,701,569	17.00
18.00	Ancillary services	22,042,779	714	22,043,493	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	42,744,348	714	42,745,062	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		20,529,891		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)		20,529,891		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-3025 | Period: From 01/01/2022 To 07/31/2022 | Worksheet G-3 | Date/Time Prepared: 11/22/2022 12:05 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	42,745,062	1.00
2.00	Less contractual allowances and discounts on patients' accounts	12,935,985	2.00
3.00	Net patient revenues (line 1 minus line 2)	29,809,077	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	20,529,891	4.00
5.00	Net income from service to patients (line 3 minus line 4)	9,279,186	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	84,393	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER (SPECIFY)	0	24.00
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	84,393	25.00
26.00	Total (line 5 plus line 25)	9,363,579	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)	9,363,579	29.00