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: 15-0047	Period: From 06/01/2021 To 05/31/2022	Worksheet S Parts I-III Date/Time Prepared: 10/28/2022 2:52 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 10/28/2022 Time: 2:52 pm
2. [ ] Manually prepared cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

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

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by LUTHERAN DOWNTOWN HOSPITAL (15-0047) for the cost reporting period beginning 06/01/2021 and ending 05/31/2022 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				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				2
3	Signatory Title				3
4	Date				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	720,735	-31,993	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing Bed - SNF	0	129	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7.00
200.00	Total	0	720,864	-31,993	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0047 | Period: From 06/01/2021 To 05/31/2022 | Worksheet S-2 Part I | Date/Time Prepared: 10/28/2022 2:52 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 702 VAN BUREN ST	PO Box:			1.00
2.00	City: FORT WAYNE	State: IN	Zip Code: 46802	County: ALLEN	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	LUTHERAN DOWNTOWN HOSPITAL	150047	23060	1	07/01/1996	N	P	P	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	LUTHERAN DOWNTOWN SWING BEDS	15U047	23060		01/31/2022	N	P	P	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	06/01/2021	05/31/2022	20.00
21.00	Type of Control (see instructions)	4		21.00

		1.00	2.00	3.00	
	Inpatient PPS Information				
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	Y	N		22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	Y	Y		22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or “N” for no.	N	N	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: 15-0047 | Period: From 06/01/2021 To 05/31/2022 | Worksheet S-2 Part I | Date/Time Prepared: 10/28/2022 2:52 pm

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	547	99	0	30	2,757	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00

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

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

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

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	Y	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.	Y	Y		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.	N			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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0047 | Period: From 06/01/2021 To 05/31/2022 | Worksheet S-2 Part I Date/Time Prepared: 10/28/2022 2:52 pm

		NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
		1.00	2.00	3.00	
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustement? Enter "Y" for yes or "N" for no in column 2.	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: 15-0047 | Period: From 06/01/2021 To 05/31/2022 | Worksheet S-2 Part I | Date/Time Prepared: 10/28/2022 2:52 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)	N	N	0	71.00
	Inpatient Rehabilitation Facility PPS				
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N			75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)	N	N	0	76.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0047 | Period: From 06/01/2021 To 05/31/2022 | Worksheet S-2 Part I Date/Time Prepared: 10/28/2022 2:52 pm

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

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	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.	Y	Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.06
	Rural Providers			
105.00	Does this hospital qualify as a CAH?	N		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			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: 15-0047 | Period: From 06/01/2021 To 05/31/2022 | Worksheet S-2 Part I Date/Time Prepared: 10/28/2022 2:52 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.	N			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:	117,875	21,056	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
	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	HB1848	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0047 | Period: From 06/01/2021 To 05/31/2022 | Worksheet S-2 Part I | Date/Time Prepared: 10/28/2022 2:52 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: COMMUNITY HEALTH SYSTEMS	Contractor's Name: WPS, INC.	Contractor's Number: 10301	141.00
142.00	Street: 4000 MERIDIAN BLVD	PO Box:		142.00
143.00	City: FRANKLIN	State: TN	Zip Code: 37067	143.00

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

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

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

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

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-0047 | Period: From 06/01/2021 To 05/31/2022 | Worksheet S-2 Part II | Date/Time Prepared: 10/28/2022 2:52 pm

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

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

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	N			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.	Y		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.	Y	15.00

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	08/29/2022	Y	08/29/2022	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-0047 | Period: From 06/01/2021 To 05/31/2022 | Worksheet S-2 Part II | Date/Time Prepared: 10/28/2022 2:52 pm

		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				N	33.00
	Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				N	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.				N	35.00
				Y/N	Date	
				1.00	2.00	
	Home Office Costs					
36.00	Were home office costs claimed on the cost report?			Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			Y		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			Y	12/31/2021	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			N		40.00
		1.00		2.00		
	Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	VICTORIA		ROMANKO		41.00
42.00	Enter the employer/company name of the cost report preparer.	COMMUNITY HEALTH SYSTEMS				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	(615) 925-4333		VICTORIA_ROMANKO@CHS.NET		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-0047	Period: From 06/01/2021 To 05/31/2022	Worksheet S-2 Part II Date/Time Prepared: 10/28/2022 2:52 pm

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-0047 | Period: From 06/01/2021 To 05/31/2022 | Worksheet S-3 Part I Date/Time Prepared: 10/28/2022 2:52 pm

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	48	19,678	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)		48	19,678	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	12	2,388	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		60	22,066	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	44.00	0	0		0	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		60				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-0047 | Period: From 06/01/2021 To 05/31/2022 | Worksheet S-3 Part I | Date/Time Prepared: 10/28/2022 2:52 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	892	467	5,817			1.00
2.00	HMO and other (see instructions)	1,628	2,886				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	89	0	274			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)	981	467	6,091			7.00
8.00	INTENSIVE CARE UNIT	196	80	1,613			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)	1,177	547	7,704	0.85	229.22	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	0	0	0	0.00	0.00	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			14			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)				0.85	229.22	27.00
28.00	Observation Bed Days		0	774			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			26			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: 15-0047 | Period: From 06/01/2021 To 05/31/2022 | Worksheet S-3 Part I | Date/Time Prepared: 10/28/2022 2:52 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	204	778	1,501	1.00
2.00	HMO and other (see instructions)			283	0		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	204	778	1,501	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	0.00					19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0047 | Period: From 06/01/2021 To 05/31/2022 | Worksheet S-3 Part II Date/Time Prepared: 10/28/2022 2:52 pm

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	17,473,234	0	17,473,234	476,782.00	36.65	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician and Non Physician-Part B		0	0	0	0.00	0.00	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		0	0	0	0.00	0.00	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		4,273,457	0	4,273,457	31,682.00	134.89	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		941,880	0	941,880	18,151.00	51.89	13.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00	14.00
14.01	Home office salaries		1,633,068	0	1,633,068	37,590.00	43.44	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)		4,843,325	0	4,843,325			17.00
18.00	Wage-related costs (other) (see instructions)							18.00
19.00	Excluded areas		0	0	0			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)		364,450	0	364,450			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: 15-0047 | Period: From 06/01/2021 To 05/31/2022 | Worksheet S-3 Part II | Date/Time Prepared: 10/28/2022 2:52 pm

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.53	Home office: Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	148,190	0	148,190	4,052.00	36.57	26.00
27.00	Administrative & General	5.00	3,439,207	-241,756	3,197,451	93,903.00	34.05	27.00
28.00	Administrative & General under contract (see inst.)		308,867	0	308,867	776.00	398.02	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	945,358	0	945,358	37,102.00	25.48	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	469,269	0	469,269	27,243.00	17.23	32.00
33.00	Housekeeping under contract (see instructions)		1,350	0	1,350	48.00	28.13	33.00
34.00	Dietary	10.00	618	-123	495	10.54	46.96	34.00
35.00	Dietary under contract (see instructions)		441,339	0	441,339	21,518.00	20.51	35.00
36.00	Cafeteria	11.00	0	123	123	1.46	84.25	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,339,382	241,756	1,581,138	30,271.00	52.23	38.00
39.00	Central Services and Supply	14.00	198,812	0	198,812	8,381.00	23.72	39.00
40.00	Pharmacy	15.00	643,595	0	643,595	11,977.00	53.74	40.00
41.00	Medical Records & Medical Records Library	16.00	3,061	0	3,061	117.00	26.16	41.00
42.00	Social Service	17.00	242,075	0	242,075	5,812.00	41.65	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0047 | Period: From 06/01/2021 To 05/31/2022 | Worksheet S-3 Part III Date/Time Prepared: 10/28/2022 2:52 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		18,224,790	0	18,224,790	499,124.00	36.51	1.00
2.00	Excluded area salaries (see instructions)		0	0	0	0.00	0.00	2.00
3.00	Subtotal salaries (line 1 minus line 2)		18,224,790	0	18,224,790	499,124.00	36.51	3.00
4.00	Subtotal other wages & related costs (see inst.)		6,848,405	0	6,848,405	87,423.00	78.34	4.00
5.00	Subtotal wage-related costs (see inst.)		5,207,775	0	5,207,775	0.00	28.58	5.00
6.00	Total (sum of lines 3 thru 5)		30,280,970	0	30,280,970	586,547.00	51.63	6.00
7.00	Total overhead cost (see instructions)		8,181,123	0	8,181,123	241,212.00	33.92	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 15-0047 | Period: From 06/01/2021 To 05/31/2022 | Worksheet S-3 Part IV Date/Time Prepared: 10/28/2022 2:52 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	325,853	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)	2,949,031	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	4,902	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	12,654	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)	7,112	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	268,981	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	1,007,512	17.00
18.00	Medicare Taxes - Employers Portion Only	235,628	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	31,652	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	0	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	4,843,325	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: 15-0047 | Period: From 06/01/2021 To 05/31/2022 | Worksheet S-3 Part V | Date/Time Prepared: 10/28/2022 2:52 pm

	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	4,273,457	4,843,325	1.00
2.00	Hospital	4,273,457	4,843,325	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	0	0	8.00
9.00	NURSING FACILITY			9.00
10.00	OTHER LONG TERM CARE I			10.00
11.00	Hospital-Based HHA			11.00
12.00	AMBULATORY SURGICAL CENTER (D.P.) I			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	RENAL DIALYSIS I			17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-0047 | Period: From 06/01/2021 To 05/31/2022 | Worksheet S-10 | Date/Time Prepared: 10/28/2022 2:52 pm

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.338881	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	10,463,704	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	Y	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	100,058,222	6.00
7.00	Medicaid cost (line 1 times line 6)	33,907,830	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	23,444,126	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	23,444,126	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	5,854,632	0	5,854,632	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	1,984,024	0	1,984,024	21.00
22.00	Payments received from patients for amounts previously written off as charity care	5,495	0	5,495	22.00
23.00	Cost of charity care (line 21 minus line 22)	1,978,529	0	1,978,529	23.00

		1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	4,729,846	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	92,979	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	143,044	27.01
28.00	Non-Medicare bad debt expense (see instructions)	4,586,802	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	1,604,445	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	3,582,974	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	27,027,100	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0047 | Period: From 06/01/2021 To 05/31/2022 | Worksheet A | Date/Time Prepared: 10/28/2022 2:52 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		7,574,433	7,574,433	3,971,327	11,545,760	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		8,240,159	8,240,159	735,777	8,975,936	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	148,190	144,041	292,231	3,601,120	3,893,351	4.00
5.01	00590	REVENUE CYCLE	892,758	3,899,244	4,792,002	-158,863	4,633,139	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	17,462	57,123	74,585	-2	74,583	5.02
5.03	00591	ADMINISTRATIVE AND GENERAL	2,528,987	16,824,447	19,353,434	-7,782,902	11,570,532	5.03
7.00	00700	OPERATION OF PLANT	945,358	2,245,679	3,191,037	427,436	3,618,473	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	114,403	114,403	0	114,403	8.00
9.00	00900	HOUSEKEEPING	469,269	277,428	746,697	-5,496	741,201	9.00
10.00	01000	DIETARY	618	1,311,594	1,312,212	-642,413	669,799	10.00
11.00	01100	CAFETERIA	0	0	0	634,683	634,683	11.00
13.00	01300	NURSING ADMINISTRATION	1,339,382	126,953	1,466,335	241,624	1,707,959	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	198,812	394,095	592,907	-452,533	140,374	14.00
15.00	01500	PHARMACY	643,595	1,423,392	2,066,987	-1,234,829	832,158	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,061	199,295	202,356	96	202,452	16.00
17.00	01700	SOCIAL SERVICE	242,075	51,296	293,371	0	293,371	17.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	68,774	68,774	0	68,774	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,362,168	2,371,725	5,733,893	-3,879	5,730,014	30.00
31.00	03100	INTENSIVE CARE UNIT	768,114	2,246,639	3,014,753	-2,777	3,011,976	31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	405,084	1,430,082	1,835,166	-240,423	1,594,743	50.00
51.00	05100	RECOVERY ROOM	157,994	240,249	398,243	-316	397,927	51.00
53.00	05300	ANESTHESIOLOGY	0	912,303	912,303	0	912,303	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	671,249	213,133	884,382	391,558	1,275,940	54.00
54.01	03630	ULTRA SOUND	201,410	28,704	230,114	-230,114	0	54.01
56.00	05600	RADIOISOTOPE	50,226	49,876	100,102	-100,102	0	56.00
57.00	05700	CT SCAN	142,473	99,946	242,419	-242,419	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	71,140	5,105	76,245	-76,245	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	45,181	64,347	109,528	-21,930	87,598	59.00
60.00	06000	LABORATORY	1,256,956	1,072,720	2,329,676	-74,489	2,255,187	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	61,050	61,050	0	61,050	62.00
65.00	06500	RESPIRATORY THERAPY	699,382	111,616	810,998	-6,267	804,731	65.00
66.00	06600	PHYSICAL THERAPY	145,621	13,243	158,864	555	159,419	66.00
67.00	06700	OCCUPATIONAL THERAPY	99,900	7,810	107,710	0	107,710	67.00
68.00	06800	SPEECH PATHOLOGY	8,414	684	9,098	0	9,098	68.00
69.00	06900	ELECTROCARDIOLOGY	158,153	12,405	170,558	-390	170,168	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	238,255	238,255	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	23,987	23,987	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,012,126	1,012,126	73.00
76.00	03950	MISC ANCILLARY	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	1,800,202	3,499,512	5,299,714	-2,155	5,297,559	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	17,473,234	55,393,505	72,866,739	0	72,866,739	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	MEALS ON WHEELS	0	0	0	0	0	194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	17,473,234	55,393,505	72,866,739	0	72,866,739	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0047 | Period: From 06/01/2021 To 05/31/2022 | Worksheet A | Date/Time Prepared: 10/28/2022 2:52 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	155,322	11,701,082		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	4,639,392	13,615,328		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-63,698	3,829,653		4.00
5.01	00590	REVENUE CYCLE	286,736	4,919,875		5.01
5.02	00560	PURCHASING RECEIVING AND STORES	0	74,583		5.02
5.03	00591	ADMINISTRATIVE AND GENERAL	-754,369	10,816,163		5.03
7.00	00700	OPERATION OF PLANT	-10,731	3,607,742		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	114,403		8.00
9.00	00900	HOUSEKEEPING	0	741,201		9.00
10.00	01000	DIETARY	0	669,799		10.00
11.00	01100	CAFETERIA	0	634,683		11.00
13.00	01300	NURSING ADMINISTRATION	0	1,707,959		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	140,374		14.00
15.00	01500	PHARMACY	0	832,158		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-174	202,278		16.00
17.00	01700	SOCIAL SERVICE	0	293,371		17.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	68,774		22.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-1,292,016	4,437,998		30.00
31.00	03100	INTENSIVE CARE UNIT	0	3,011,976		31.00
44.00	04400	SKILLED NURSING FACILITY	0	0		44.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-250,000	1,344,743		50.00
51.00	05100	RECOVERY ROOM	0	397,927		51.00
53.00	05300	ANESTHESIOLOGY	0	912,303		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,275,940		54.00
54.01	03630	ULTRA SOUND	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	-41,610	45,988		59.00
60.00	06000	LABORATORY	0	2,255,187		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	61,050		62.00
65.00	06500	RESPIRATORY THERAPY	0	804,731		65.00
66.00	06600	PHYSICAL THERAPY	0	159,419		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	107,710		67.00
68.00	06800	SPEECH PATHOLOGY	0	9,098		68.00
69.00	06900	ELECTROCARDIOLOGY	0	170,168		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	238,255		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	23,987		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,012,126		73.00
76.00	03950	MISC ANCILLARY	0	0		76.00
76.01	03951	SLEEP LAB	0	0		76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0		76.02
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	-1,173,016	4,124,543		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,495,836	74,362,575		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
194.00	07950	MEALS ON WHEELS	0	0		194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	1,495,836	74,362,575		200.00

RECLASSIFICATIONS | Provider CCN: 15-0047 | Period: From 06/01/2021 To 05/31/2022 | Worksheet A-6 | Date/Time Prepared: 10/28/2022 2:52 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - EMPLOYEE BENEFITS				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	3,603,191	1.00
2.00		0.00	0	0	2.00
	0		0	3,603,191	
	C - LEASE AND RENTAL				
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	725,268	1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	99,950	2.00
3.00	MEDICAL RECORDS & LIBRARY	16.00	0	96	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
	0		0	825,314	
	D - OTHER CAPITAL COSTS				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	365,140	1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	3,506,237	2.00
3.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	10,509	3.00
	0		0	3,881,886	
	E - REPAIRS & MAINTENANCE				
1.00	OPERATION OF PLANT	7.00	0	384,854	1.00
2.00	PHYSICAL THERAPY	66.00	0	555	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
	0		0	385,409	
	F - CNO WAGES RECLASS				
1.00	NURSING ADMINISTRATION	13.00	241,756	0	1.00
	0		241,756	0	
	G - MEDICAL SUPPLIES				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	238,255	1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	23,987	2.00
3.00		0.00	0	0	3.00
	0		0	262,242	
	H - DRUGS AND IV COSTS				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	1,012,126	1.00
	0		0	1,012,126	
	J - RADIOLOGY				
1.00	RADIOLOGY-DIAGNOSTIC	54.00	465,249	92,818	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
	0		465,249	92,818	
	K - DIETARY				
1.00	CAFETERIA	11.00	123	634,560	1.00
	0		123	634,560	
	M - UTILITIES RECLASS				
1.00	OPERATION OF PLANT	7.00	0	57,457	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
	0		0	57,457	

RECLASSIFICATIONS | Provider CCN: 15-0047 | Period: From 06/01/2021 To 05/31/2022 | Worksheet A-6 | Date/Time Prepared: 10/28/2022 2:52 pm

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	N - NON-CAPITALIZED EQUIPMENT				
1.00	OPERATING ROOM	50.00	0	14,940	1.00
2.00		0.00	0	0	2.00
	0		0	14,940	
500.00	Grand Total: Increases		707,128	10,769,943	500.00

RECLASSIFICATIONS | Provider CCN: 15-0047 | Period: From 06/01/2021 To 05/31/2022 | Worksheet A-6 | Date/Time Prepared: 10/28/2022 2:52 pm

		Decreases				
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	A - EMPLOYEE BENEFITS					
1.00	ADMINISTRATIVE AND GENERAL	5.03	0	3,603,167	0	1.00
2.00	REVENUE CYCLE	5.01	0	24	0	2.00
	0		0	3,603,191		
	C - LEASE AND RENTAL					
1.00	ADMINISTRATIVE AND GENERAL	5.03	0	20,297	10	1.00
2.00	OPERATION OF PLANT	7.00	0	349	10	2.00
3.00	DIETARY	10.00	0	990	0	3.00
4.00	NURSING ADMINISTRATION	13.00	0	132	0	4.00
5.00	PHARMACY	15.00	0	219,408	0	5.00
6.00	ADULTS & PEDIATRICS	30.00	0	107	0	6.00
7.00	RADIOLOGY-DIAGNOSTIC	54.00	0	96,078	0	7.00
8.00	LABORATORY	60.00	0	70,158	0	8.00
9.00	CARDIAC CATHETERIZATION	59.00	0	14,853	0	9.00
10.00	REVENUE CYCLE	5.01	0	136	0	10.00
11.00	OPERATING ROOM	50.00	0	232,883	0	11.00
12.00	CENTRAL SERVICES & SUPPLY	14.00	0	167,852	0	12.00
13.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	2,071	0	13.00
	0		0	825,314		
	D - OTHER CAPITAL COSTS					
1.00	ADMINISTRATIVE AND GENERAL	5.03	0	3,881,886	12	1.00
2.00		0.00	0	0	13	2.00
3.00		0.00	0	0	12	3.00
	0		0	3,881,886		
	E - REPAIRS & MAINTENANCE					
1.00	INTENSIVE CARE UNIT	31.00	0	2,777	0	1.00
2.00	REVENUE CYCLE	5.01	0	140,822	0	2.00
3.00	ADMINISTRATIVE AND GENERAL	5.03	0	28,291	0	3.00
4.00	HOUSEKEEPING	9.00	0	5,496	0	4.00
5.00	RECOVERY ROOM	51.00	0	316	0	5.00
6.00	CENTRAL SERVICES & SUPPLY	14.00	0	23,083	0	6.00
7.00	ADULTS & PEDIATRICS	30.00	0	3,772	0	7.00
8.00	PHARMACY	15.00	0	3,295	0	8.00
9.00	OPERATING ROOM	50.00	0	22,480	0	9.00
10.00	RADIOLOGY-DIAGNOSTIC	54.00	0	37,946	0	10.00
11.00	ULTRA SOUND	54.01	0	13,414	0	11.00
12.00	PURCHASING RECEIVING AND STORES	5.02	0	2	0	12.00
13.00	CT SCAN	57.00	0	77,399	0	13.00
14.00	LABORATORY	60.00	0	4,331	0	14.00
15.00	RESPIRATORY THERAPY	65.00	0	6,013	0	15.00
16.00	DIETARY	10.00	0	6,740	0	16.00
17.00	CARDIAC CATHETERIZATION	59.00	0	7,077	0	17.00
18.00	EMERGENCY	91.00	0	2,155	0	18.00
	0		0	385,409		
	F - CNO WAGES RECLASS					
1.00	ADMINISTRATIVE AND GENERAL	5.03	241,756	0	0	1.00
	0		241,756	0		
	G - MEDICAL SUPPLIES					
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	261,598	0	1.00
2.00	RESPIRATORY THERAPY	65.00	0	254	0	2.00
3.00	ELECTROCARDIOLOGY	69.00	0	390	0	3.00
	0		0	262,242		
	H - DRUGS AND IV COSTS					
1.00	PHARMACY	15.00	0	1,012,126	0	1.00
	0		0	1,012,126		
	J - RADIOLOGY					
1.00	ULTRA SOUND	54.01	201,410	15,290	0	1.00
2.00	RADIOISOTOPE	56.00	50,226	49,876	0	2.00
3.00	CT SCAN	57.00	142,473	22,547	0	3.00
4.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	71,140	5,105	0	4.00
	0		465,249	92,818		
	K - DIETARY					
1.00	DIETARY	10.00	123	634,560	0	1.00
	0		123	634,560		
	M - UTILITIES RECLASS					
1.00	ADMINISTRATIVE AND GENERAL	5.03	0	7,505	0	1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	0	32,485	0	2.00
3.00	REVENUE CYCLE	5.01	0	17,467	0	3.00
	0		0	57,457		

RECLASSIFICATIONS | Provider CCN: 15-0047 | Period: From 06/01/2021 To 05/31/2022 | Worksheet A-6 | Date/Time Prepared: 10/28/2022 2:52 pm

	Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	N - NON-CAPITALIZED EQUIPMENT					
1.00	REVENUE CYCLE	5.01	0	414	0	1.00
2.00	OPERATION OF PLANT	7.00	0	14,526	0	2.00
	0		0	14,940		
500.00	Grand Total: Decreases		707,128	10,769,943		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0047 | Period: From 06/01/2021 To 05/31/2022 | Worksheet A-7 Part I | Date/Time Prepared: 10/28/2022 2:52 pm

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	9,348,028	0	0	0	0	1.00
2.00	Land Improvements	1,775,835	0	0	0	1,764,691	2.00
3.00	Buildings and Fixtures	28,513,304	85,396,042	0	85,396,042	26,798,114	3.00
4.00	Building Improvements	31,930,883	120,472	0	120,472	30,641,632	4.00
5.00	Fixed Equipment	18,375,197	961,755	0	961,755	18,222,416	5.00
6.00	Movable Equipment	65,013,592	23,386,552	0	23,386,552	40,067,951	6.00
7.00	HIT designated Assets	2,855,680	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	157,812,519	109,864,821	0	109,864,821	117,494,804	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	157,812,519	109,864,821	0	109,864,821	117,494,804	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	9,348,028	0	1.00
2.00	Land Improvements	11,144	0	2.00
3.00	Buildings and Fixtures	87,111,232	0	3.00
4.00	Building Improvements	1,409,723	0	4.00
5.00	Fixed Equipment	1,114,536	0	5.00
6.00	Movable Equipment	48,332,193	0	6.00
7.00	HIT designated Assets	2,855,680	0	7.00
8.00	Subtotal (sum of lines 1-7)	150,182,536	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	150,182,536	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0047 | Period: From 06/01/2021 To 05/31/2022 | Worksheet A-7 Part II | Date/Time Prepared: 10/28/2022 2:52 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	7,574,433	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	8,240,159	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	15,814,592	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL		
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	7,574,433	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	8,240,159	2.00
3.00	Total (sum of lines 1-2)	0	15,814,592	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0047 | Period: From 06/01/2021 To 05/31/2022 | Worksheet A-7 Part III | Date/Time Prepared: 10/28/2022 2:52 pm

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	97,880,127	0	97,880,127	0.651741	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	52,302,409	0	52,302,409	0.348259	0	2.00
3.00	Total (sum of lines 1-2)	150,182,536	0	150,182,536	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	6,662,034	99,950	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	12,878,477	726,342	2.00
3.00	Total (sum of lines 1-2)	0	0	0	19,540,511	826,292	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	1,067,721	365,140	3,506,237	0	11,701,082	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	10,509	0	0	13,615,328	2.00
3.00	Total (sum of lines 1-2)	1,067,721	375,649	3,506,237	0	25,316,410	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0047 | Period: From 06/01/2021 To 05/31/2022 | Worksheet A-8 | Date/Time Prepared: 10/28/2022 2:52 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	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)	A	-1,893	ADMINISTRATIVE AND GENERAL	5.03	0	7.00
8.00	Television and radio service (chapter 21)	A	-10,731	OPERATION OF PLANT	7.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-2,843,451			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	1,291,288			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	B	-174	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
19.01	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.01
20.00	Vending machines	B	-399	ADMINISTRATIVE AND GENERAL	5.03	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	A	-914,343	CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	A	4,535,686	CAP REL COSTS-MVBLE EQUIP	2.00	9	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)	A	-13,691	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

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0047 | Period: From 06/01/2021 To 05/31/2022 | Worksheet A-8 | Date/Time Prepared: 10/28/2022 2:52 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	PARKING GARAGE & MISC INCOME	B	-29,781	ADMINISTRATIVE AND GENERAL	5.03	0	33.00
33.01	MARKETING & RECRUITING EXPENSE	A	-230,946	ADMINISTRATIVE AND GENERAL	5.03	0	33.01
33.02	RENTAL INCOME	B	-50,724	CAP REL COSTS-BLDG & FIXT	1.00	9	33.02
33.03	FITNESS REVENUE	B	-2,016	ADMINISTRATIVE AND GENERAL	5.03	0	33.03
33.04	SENIOR CIRCLE	A	-9	ADMINISTRATIVE AND GENERAL	5.03	0	33.04
33.05	SILVER RECOVERY	B	-1,297	ADMINISTRATIVE AND GENERAL	5.03	0	33.05
33.06	PATIENT PHONE WAGE COSTS	A	-6,211	ADMINISTRATIVE AND GENERAL	5.03	0	33.06
33.07	PATIENT PHONES BENEFITS	A	-1,722	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.07
33.08	PATIENT PHONE DEPRECIATION	A	-93	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.08
33.09	PATIENT TV DEPRECIATION	A	-290	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.09
33.10	INTEREST INCOME ADD BACK	A	3,897	ADMINISTRATIVE AND GENERAL	5.03	0	33.10
33.11	PHYSICIAN RECRUITING	A	-61,976	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.11
33.12	LOBBYING EXPENSE IN DUES	A	-2,804	ADMINISTRATIVE AND GENERAL	5.03	0	33.12
33.13	CHARITABLE CONTRIBUTIONS	A	-69,595	ADMINISTRATIVE AND GENERAL	5.03	0	33.13
33.14	RECRUITING FEES	A	-5,604	ADMINISTRATIVE AND GENERAL	5.03	0	33.14
33.16	NONALLOWABLE LEGAL EXPENSES	A	-87,285	ADMINISTRATIVE AND GENERAL	5.03	0	33.16
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		1,495,836				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: 15-0047 | Period: From 06/01/2021 To 05/31/2022 | Worksheet A-8-1 | Date/Time Prepared: 10/28/2022 2:52 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.00	CAP REL COSTS-BLDG & FIXT	CAPITAL-RELATED INTEREST	1,067,721	0	1.00
2.00	1.00	CAP REL COSTS-BLDG & FIXT	PASI CAPITAL COSTS - BLDG &	4,015	0	2.00
3.00	2.00	CAP REL COSTS-MVBLE EQUIP	PASI CAPITAL COSTS - MOVEABL	838	0	3.00
4.00	5.01	REVENUE CYCLE	Capital-Related Interest	286,736	0	4.00
4.04	5.03	ADMINISTRATIVE AND GENERAL	Shared Service Center Alloca	1,024,482	826,951	4.04
4.05	1.00	CAP REL COSTS-BLDG & FIXT	New Capital - Building & Fix	48,653	0	4.05
4.06	2.00	CAP REL COSTS-MVBLE EQUIP	New Capital - Movable Equipm	102,177	0	4.06
4.07	5.03	ADMINISTRATIVE AND GENERAL	Non-Capital Home Office Cost	1,901,815	0	4.07
4.08	5.03	ADMINISTRATIVE AND GENERAL	Malpractice Costs	138,931	221,502	4.08
4.09	2.00	CAP REL COSTS-MVBLE EQUIP	CIG Leased Equipment	84,870	83,796	4.09
4.10	5.03	ADMINISTRATIVE AND GENERAL	Management Fees	0	1,018,396	4.10
4.11	5.03	ADMINISTRATIVE AND GENERAL	401K Fees	0	4,609	4.11
4.12	5.03	ADMINISTRATIVE AND GENERAL	Audit Fees	0	34,198	4.12
4.13	5.03	ADMINISTRATIVE AND GENERAL	Corporate Overhead Allocatio	0	709,971	4.13
4.14	5.03	ADMINISTRATIVE AND GENERAL	HIIM Allocation	0	179,441	4.14
4.15	5.03	ADMINISTRATIVE AND GENERAL	Contract Management	0	26,303	4.15
4.16	5.03	ADMINISTRATIVE AND GENERAL	PASI Lien Unit Collection Fe	0	8,471	4.16
4.17	5.03	ADMINISTRATIVE AND GENERAL	PASI COLLECTION FEES	0	255,312	4.17
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			4,660,238	3,368,950	5.00

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

				Related Organization(s) and/or Home Office		
	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	
	1.00	2.00	3.00	4.00	5.00	
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:					

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

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

6.00	B		0.00	CHS, INC	100.00	6.00
7.00	B		0.00	PASI	100.00	7.00
8.00	C		33.00	SHARED LAUNDRY	33.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 15-0047 | Period: From 06/01/2021 To 05/31/2022 | Worksheet A-8-1 | Date/Time Prepared: 10/28/2022 2:52 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	1,067,721	11		1.00
2.00	4,015	9		2.00
3.00	838	9		3.00
4.00	286,736	0		4.00
4.04	197,531	0		4.04
4.05	48,653	9		4.05
4.06	102,177	9		4.06
4.07	1,901,815	0		4.07
4.08	-82,571	0		4.08
4.09	1,074	10		4.09
4.10	-1,018,396	0		4.10
4.11	-4,609	0		4.11
4.12	-34,198	0		4.12
4.13	-709,971	0		4.13
4.14	-179,441	0		4.14
4.15	-26,303	0		4.15
4.16	-8,471	0		4.16
4.17	-255,312	0		4.17
5.00	1,291,288			5.00

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

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

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

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

6.00	OWNER		6.00
7.00	DEBT COLLECTION		7.00
8.00	LAUNDRY		8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-0047 | Period: From 06/01/2021 To 05/31/2022 | Worksheet A-8-2 | Date/Time Prepared: 10/28/2022 2:52 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.03	ADMINISTRATIVE AND GENERAL	100,500	100,500	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	1,278,325	1,278,325	0	0	0	2.00
3.00	50.00	OPERATING ROOM	250,000	250,000	0	0	0	3.00
4.00	59.00	CARDIAC CATHETERIZATION	41,610	41,610	0	0	0	4.00
5.00	91.00	EMERGENCY	1,173,016	1,173,016	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			2,843,451	2,843,451	0		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.03	ADMINISTRATIVE AND GENERAL	0	0	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	50.00	OPERATING ROOM	0	0	0	0	0	3.00
4.00	59.00	CARDIAC CATHETERIZATION	0	0	0	0	0	4.00
5.00	91.00	EMERGENCY	0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.03	ADMINISTRATIVE AND GENERAL	0	0	0	100,500		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	1,278,325		2.00
3.00	50.00	OPERATING ROOM	0	0	0	250,000		3.00
4.00	59.00	CARDIAC CATHETERIZATION	0	0	0	41,610		4.00
5.00	91.00	EMERGENCY	0	0	0	1,173,016		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	2,843,451		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0047 | Period: From 06/01/2021 To 05/31/2022 | Worksheet B Part I Date/Time Prepared: 10/28/2022 2:52 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	REVENUE CYCLE	
			0	1.00	2.00	4.00	5.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	11,701,082	11,701,082				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	13,615,328		13,615,328			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,829,653	82,554	96,059	4,008,266		4.00
5.01	00590	REVENUE CYCLE	4,919,875	292,886	340,801	206,546	5,760,108	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	74,583	203,404	236,680	4,040	0	5.02
5.03	00591	ADMINISTRATIVE AND GENERAL	10,816,163	767,844	893,460	529,167	0	5.03
7.00	00700	OPERATION OF PLANT	3,607,742	3,386,981	3,941,077	218,715	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	114,403	64,834	75,440	0	0	8.00
9.00	00900	HOUSEKEEPING	741,201	981,452	1,142,013	108,569	0	9.00
10.00	01000	DIETARY	669,799	457,994	532,920	115	0	10.00
11.00	01100	CAFETERIA	634,683	99,308	115,555	28	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,707,959	112,325	130,701	365,807	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	140,374	0	0	45,997	0	14.00
15.00	01500	PHARMACY	832,158	72,770	84,675	148,900	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	202,278	183,710	213,764	708	0	16.00
17.00	01700	SOCIAL SERVICE	293,371	0	0	56,006	0	17.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	68,774	0	0	0	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,437,998	1,610,936	1,874,479	777,855	517,823	30.00
31.00	03100	INTENSIVE CARE UNIT	3,011,976	324,043	377,055	177,709	266,340	31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,344,743	727,155	846,115	93,719	118,567	50.00
51.00	05100	RECOVERY ROOM	397,927	101,744	118,389	36,553	27,232	51.00
53.00	05300	ANESTHESIOLOGY	912,303	0	0	0	22,553	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,275,940	772,421	898,786	262,937	1,540,642	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	45,988	32,123	37,378	10,453	4,473	59.00
60.00	06000	LABORATORY	2,255,187	326,185	379,547	290,806	939,723	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	61,050	13,521	15,733	0	15,207	62.00
65.00	06500	RESPIRATORY THERAPY	804,731	124,881	145,311	161,807	234,644	65.00
66.00	06600	PHYSICAL THERAPY	159,419	130,298	151,614	33,690	29,327	66.00
67.00	06700	OCCUPATIONAL THERAPY	107,710	49,885	58,046	23,113	25,002	67.00
68.00	06800	SPEECH PATHOLOGY	9,098	19,232	22,378	1,947	1,993	68.00
69.00	06900	ELECTROCARDIOLOGY	170,168	18,266	21,254	36,590	59,261	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	238,255	0	0	0	93,586	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	23,987	0	0	0	10,343	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,012,126	43,209	50,277	0	713,675	73.00
76.00	03950	MISC ANCILLARY	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	37,204	43,290	0	6,323	90.00
91.00	09100	EMERGENCY	4,124,543	646,197	751,912	416,489	1,133,394	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	74,362,575	11,683,362	13,594,709	4,008,266	5,760,108	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	17,720	20,619	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	MEALS ON WHEELS	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	74,362,575	11,701,082	13,615,328	4,008,266	5,760,108	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0047 | Period: From 06/01/2021 To 05/31/2022 | Worksheet B Part I | Date/Time Prepared: 10/28/2022 2:52 pm

		Cost Center Description	PURCHASING RECEIVING AND STORES	Subtotal	ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			5.02	5A.02	5.03	7.00	8.00	
		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
5.01	00590	REVENUE CYCLE						5.01
5.02	00560	PURCHASING RECEIVING AND STORES	518,707					5.02
5.03	00591	ADMINISTRATIVE AND GENERAL	40,295	13,046,929	13,046,929			5.03
7.00	00700	OPERATION OF PLANT	2,757	11,157,272	2,374,080	13,531,352		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	254,677	54,191	125,913	434,781	8.00
9.00	00900	HOUSEKEEPING	14,655	2,987,890	635,772	1,906,069	0	9.00
10.00	01000	DIETARY	104,857	1,765,685	375,708	889,466	0	10.00
11.00	01100	CAFETERIA	0	849,574	180,775	192,866	0	11.00
13.00	01300	NURSING ADMINISTRATION	766	2,317,558	493,137	218,146	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	17,545	203,916	43,390	0	0	14.00
15.00	01500	PHARMACY	0	1,138,503	242,254	141,326	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	600,460	127,768	356,781	0	16.00
17.00	01700	SOCIAL SERVICE	0	349,377	74,341	0	0	17.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	68,774	14,634	0	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	30,911	9,250,002	1,968,243	3,128,586	115,464	30.00
31.00	03100	INTENSIVE CARE UNIT	14,017	4,171,140	887,548	629,322	71,410	31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	34,506	3,164,805	673,417	1,412,202	20,429	50.00
51.00	05100	RECOVERY ROOM	485	682,330	145,188	197,596	0	51.00
53.00	05300	ANESTHESIOLOGY	0	934,856	198,921	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	4,750,726	1,010,874	1,500,113	68,427	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	130,415	27,750	62,386	0	59.00
60.00	06000	LABORATORY	116,633	4,308,081	916,686	633,481	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	12,045	117,556	25,014	26,259	0	62.00
65.00	06500	RESPIRATORY THERAPY	10,406	1,481,780	315,298	242,530	0	65.00
66.00	06600	PHYSICAL THERAPY	464	504,812	107,415	253,050	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	263,756	56,123	96,881	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	54,648	11,628	37,350	0	68.00
69.00	06900	ELECTROCARDIOLOGY	236	305,775	65,064	35,474	314	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	46,046	377,887	80,408	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	34,330	7,305	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,819,287	387,113	83,915	0	73.00
76.00	03950	MISC ANCILLARY	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	86,817	18,473	72,253	0	90.00
91.00	09100	EMERGENCY	72,083	7,144,618	1,520,253	1,254,973	158,686	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0				92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	518,707	74,324,236	13,038,771	13,496,938	434,730	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	38,339	8,158	34,414	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	51	192.00
194.00	07950	MEALS ON WHEELS	0	0	0	0	0	194.00
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)	518,707	74,362,575	13,046,929	13,531,352	434,781	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0047 | Period: From 06/01/2021 To 05/31/2022 | Worksheet B Part I | Date/Time Prepared: 10/28/2022 2:52 pm

		Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			9.00	10.00	11.00	13.00	14.00	
		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
5.01	00590	REVENUE CYCLE						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00591	ADMINISTRATIVE AND GENERAL						5.03
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	5,529,731					9.00
10.00	01000	DIETARY	427,720	3,458,579				10.00
11.00	01100	CAFETERIA	92,744	0	1,315,959			11.00
13.00	01300	NURSING ADMINISTRATION	104,901	0	126,652	3,260,394		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	35,079	0	282,385	14.00
15.00	01500	PHARMACY	67,960	0	50,138	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	171,566	0	522	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	24,286	0	0	17.00
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	1,504,450	2,989,814	342,176	1,621,234	25,838	30.00
31.00	03100	INTENSIVE CARE UNIT	302,623	468,765	63,805	428,483	11,716	31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	679,089	0	32,207	130,691	28,843	50.00
51.00	05100	RECOVERY ROOM	95,018	0	14,972	84,710	405	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	721,363	0	132,049	7,666	0	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	30,000	0	7,312	0	0	59.00
60.00	06000	LABORATORY	304,623	0	192,981	0	97,490	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	12,627	0	0	0	10,068	62.00
65.00	06500	RESPIRATORY THERAPY	116,626	0	79,299	0	8,698	65.00
66.00	06600	PHYSICAL THERAPY	121,685	0	14,537	0	388	66.00
67.00	06700	OCCUPATIONAL THERAPY	46,588	0	9,314	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	17,961	0	1,132	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	17,059	0	14,101	0	197	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	38,489	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	40,352	0	0	0	0	73.00
76.00	03950	MISC ANCILLARY	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	34,745	0	0	0	0	90.00
91.00	09100	EMERGENCY	603,482	0	175,397	987,610	60,253	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	5,513,182	3,458,579	1,315,959	3,260,394	282,385	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	16,549	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	MEALS ON WHEELS	0	0	0	0	0	194.00
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)	5,529,731	3,458,579	1,315,959	3,260,394	282,385	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0047 | Period: From 06/01/2021 To 05/31/2022 | Worksheet B Part I Date/Time Prepared: 10/28/2022 2:52 pm

		Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS APPRV	Subtotal	
			15.00	16.00	17.00	22.00	24.00	
		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
5.01	00590	REVENUE CYCLE						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00591	ADMINISTRATIVE AND GENERAL						5.03
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	1,640,181					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,257,097				16.00
17.00	01700	SOCIAL SERVICE	0	0	448,004			17.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	83,408		22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	113,014	350,746	83,408	21,492,975	30.00
31.00	03100	INTENSIVE CARE UNIT	0	58,128	97,258	0	7,190,198	31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	25,877	0	0	6,167,560	50.00
51.00	05100	RECOVERY ROOM	0	5,943	0	0	1,226,162	51.00
53.00	05300	ANESTHESIOLOGY	0	4,922	0	0	1,138,699	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	336,204	0	0	8,527,422	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	976	0	0	258,839	59.00
60.00	06000	LABORATORY	0	205,093	0	0	6,658,435	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	3,319	0	0	194,843	62.00
65.00	06500	RESPIRATORY THERAPY	0	51,211	0	0	2,295,442	65.00
66.00	06600	PHYSICAL THERAPY	0	6,401	0	0	1,008,288	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	5,457	0	0	478,119	67.00
68.00	06800	SPEECH PATHOLOGY	0	435	0	0	123,154	68.00
69.00	06900	ELECTROCARDIOLOGY	0	12,934	0	0	450,918	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	20,425	0	0	517,209	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,257	0	0	43,892	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,640,181	155,759	0	0	4,126,607	73.00
76.00	03950	MISC ANCILLARY	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	1,380	0	0	213,668	90.00
91.00	09100	EMERGENCY	0	247,362	0	0	12,152,634	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,640,181	1,257,097	448,004	83,408	74,265,064	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	97,460	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	51	192.00
194.00	07950	MEALS ON WHEELS	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,640,181	1,257,097	448,004	83,408	74,362,575	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0047 | Period: From 06/01/2021 To 05/31/2022 | Worksheet B Part I | Date/Time Prepared: 10/28/2022 2:52 pm

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			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
5.01	00590	REVENUE CYCLE				5.01
5.02	00560	PURCHASING RECEIVING AND STORES				5.02
5.03	00591	ADMINISTRATIVE AND GENERAL				5.03
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE				17.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV				22.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-83,408	21,409,567		30.00
31.00	03100	INTENSIVE CARE UNIT	0	7,190,198		31.00
44.00	04400	SKILLED NURSING FACILITY	0	0		44.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	6,167,560		50.00
51.00	05100	RECOVERY ROOM	0	1,226,162		51.00
53.00	05300	ANESTHESIOLOGY	0	1,138,699		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	8,527,422		54.00
54.01	03630	ULTRA SOUND	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	258,839		59.00
60.00	06000	LABORATORY	0	6,658,435		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	194,843		62.00
65.00	06500	RESPIRATORY THERAPY	0	2,295,442		65.00
66.00	06600	PHYSICAL THERAPY	0	1,008,288		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	478,119		67.00
68.00	06800	SPEECH PATHOLOGY	0	123,154		68.00
69.00	06900	ELECTROCARDIOLOGY	0	450,918		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	517,209		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	43,892		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	4,126,607		73.00
76.00	03950	MISC ANCILLARY	0	0		76.00
76.01	03951	SLEEP LAB	0	0		76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0		76.02
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	213,668		90.00
91.00	09100	EMERGENCY	0	12,152,634		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0			92.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-83,408	74,181,656		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	97,460		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	51		192.00
194.00	07950	MEALS ON WHEELS	0	0		194.00
200.00		Cross Foot Adjustments	0	0		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	-83,408	74,279,167		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0047 | Period: From 06/01/2021 To 05/31/2022 | Worksheet B Part II | Date/Time Prepared: 10/28/2022 2:52 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	82,554	96,059	178,613	178,613	4.00
5.01	00590	REVENUE CYCLE	0	292,886	340,801	633,687	9,204	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	0	203,404	236,680	440,084	180	5.02
5.03	00591	ADMINISTRATIVE AND GENERAL	0	767,844	893,460	1,661,304	23,581	5.03
7.00	00700	OPERATION OF PLANT	0	3,386,981	3,941,077	7,328,058	9,747	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	64,834	75,440	140,274	0	8.00
9.00	00900	HOUSEKEEPING	0	981,452	1,142,013	2,123,465	4,838	9.00
10.00	01000	DIETARY	0	457,994	532,920	990,914	5	10.00
11.00	01100	CAFETERIA	0	99,308	115,555	214,863	1	11.00
13.00	01300	NURSING ADMINISTRATION	0	112,325	130,701	243,026	16,302	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	2,050	14.00
15.00	01500	PHARMACY	0	72,770	84,675	157,445	6,635	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	183,710	213,764	397,474	32	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	2,496	17.00
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	1,610,936	1,874,479	3,485,415	34,656	30.00
31.00	03100	INTENSIVE CARE UNIT	0	324,043	377,055	701,098	7,919	31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	727,155	846,115	1,573,270	4,176	50.00
51.00	05100	RECOVERY ROOM	0	101,744	118,389	220,133	1,629	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	772,421	898,786	1,671,207	11,717	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	32,123	37,378	69,501	466	59.00
60.00	06000	LABORATORY	0	326,185	379,547	705,732	12,959	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	13,521	15,733	29,254	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	124,881	145,311	270,192	7,211	65.00
66.00	06600	PHYSICAL THERAPY	0	130,298	151,614	281,912	1,501	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	49,885	58,046	107,931	1,030	67.00
68.00	06800	SPEECH PATHOLOGY	0	19,232	22,378	41,610	87	68.00
69.00	06900	ELECTROCARDIOLOGY	0	18,266	21,254	39,520	1,631	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	43,209	50,277	93,486	0	73.00
76.00	03950	MISC ANCILLARY	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	37,204	43,290	80,494	0	90.00
91.00	09100	EMERGENCY	0	646,197	751,912	1,398,109	18,560	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	11,683,362	13,594,709	25,278,071	178,613	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	17,720	20,619	38,339	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	MEALS ON WHEELS	0	0	0	0	0	194.00
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	11,701,082	13,615,328	25,316,410	178,613	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0047 | Period: From 06/01/2021 To 05/31/2022 | Worksheet B Part II | Date/Time Prepared: 10/28/2022 2:52 pm

		Cost Center Description	REVENUE CYCLE	PURCHASING RECEIVING AND STORES	ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			5.01	5.02	5.03	7.00	8.00	
		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
5.01	00590	REVENUE CYCLE	642,891					5.01
5.02	00560	PURCHASING RECEIVING AND STORES	0	440,264				5.02
5.03	00591	ADMINISTRATIVE AND GENERAL	0	34,202	1,719,087			5.03
7.00	00700	OPERATION OF PLANT	0	2,340	312,798	7,652,943		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	7,140	71,213	218,627	8.00
9.00	00900	HOUSEKEEPING	0	12,439	83,771	1,078,018	0	9.00
10.00	01000	DIETARY	0	89,000	49,505	503,056	0	10.00
11.00	01100	CAFETERIA	0	0	23,820	109,079	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	651	64,977	123,377	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	14,892	5,717	0	0	14.00
15.00	01500	PHARMACY	0	0	31,920	79,930	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	16,835	201,785	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	9,795	0	0	17.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	1,928	0	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	57,796	26,237	259,342	1,769,439	58,060	30.00
31.00	03100	INTENSIVE CARE UNIT	29,727	11,897	116,946	355,926	35,908	31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	13,234	29,288	88,732	798,701	10,273	50.00
51.00	05100	RECOVERY ROOM	3,039	411	19,130	111,754	0	51.00
53.00	05300	ANESTHESIOLOGY	2,517	0	26,211	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	171,943	0	133,196	848,421	34,408	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	499	0	3,656	35,284	0	59.00
60.00	06000	LABORATORY	104,886	98,993	120,786	358,278	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	1,697	10,224	3,296	14,851	0	62.00
65.00	06500	RESPIRATORY THERAPY	26,190	8,832	41,545	137,168	0	65.00
66.00	06600	PHYSICAL THERAPY	3,273	394	14,153	143,118	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,791	0	7,395	54,793	0	67.00
68.00	06800	SPEECH PATHOLOGY	222	0	1,532	21,124	0	68.00
69.00	06900	ELECTROCARDIOLOGY	6,614	200	8,573	20,063	158	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	10,445	39,082	10,595	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,154	0	963	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	79,656	0	51,007	47,460	0	73.00
76.00	03950	MISC ANCILLARY	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	706	0	2,434	40,864	0	90.00
91.00	09100	EMERGENCY	126,502	61,182	200,314	709,777	79,794	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	642,891	440,264	1,718,012	7,633,479	218,601	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	1,075	19,464	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	26	192.00
194.00	07950	MEALS ON WHEELS	0	0	0	0	0	194.00
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)	642,891	440,264	1,719,087	7,652,943	218,627	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0047 | Period: From 06/01/2021 To 05/31/2022 | Worksheet B Part II | Date/Time Prepared: 10/28/2022 2:52 pm

		Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			9.00	10.00	11.00	13.00	14.00	
		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
5.01	00590	REVENUE CYCLE						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00591	ADMINISTRATIVE AND GENERAL						5.03
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	3,302,531					9.00
10.00	01000	DIETARY	255,448	1,887,928				10.00
11.00	01100	CAFETERIA	55,390	0	403,153			11.00
13.00	01300	NURSING ADMINISTRATION	62,650	0	38,801	549,784		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	10,747	0	33,406	14.00
15.00	01500	PHARMACY	40,588	0	15,360	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	102,465	0	160	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	7,440	0	0	17.00
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	898,503	1,632,044	104,828	273,380	3,057	30.00
31.00	03100	INTENSIVE CARE UNIT	180,736	255,884	19,547	72,253	1,386	31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	405,574	0	9,867	22,038	3,412	50.00
51.00	05100	RECOVERY ROOM	56,748	0	4,587	14,284	48	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	430,821	0	40,454	1,293	0	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	17,917	0	2,240	0	0	59.00
60.00	06000	LABORATORY	181,931	0	59,121	0	11,533	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	7,541	0	0	0	1,191	62.00
65.00	06500	RESPIRATORY THERAPY	69,653	0	24,294	0	1,029	65.00
66.00	06600	PHYSICAL THERAPY	72,674	0	4,453	0	46	66.00
67.00	06700	OCCUPATIONAL THERAPY	27,824	0	2,853	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	10,727	0	347	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	10,188	0	4,320	0	23	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	4,553	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	24,100	0	0	0	0	73.00
76.00	03950	MISC ANCILLARY	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	20,751	0	0	0	0	90.00
91.00	09100	EMERGENCY	360,419	0	53,734	166,536	7,128	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,292,648	1,887,928	403,153	549,784	33,406	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	9,883	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	MEALS ON WHEELS	0	0	0	0	0	194.00
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)	3,302,531	1,887,928	403,153	549,784	33,406	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0047 | Period: From 06/01/2021 To 05/31/2022 | Worksheet B Part II | Date/Time Prepared: 10/28/2022 2:52 pm

		Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS APPRV	Subtotal	
			15.00	16.00	17.00	22.00	24.00	
		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
5.01	00590	REVENUE CYCLE						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00591	ADMINISTRATIVE AND GENERAL						5.03
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	331,878					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	718,751				16.00
17.00	01700	SOCIAL SERVICE	0	0	19,731			17.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	1,928		22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	64,605	15,448		8,682,810	30.00
31.00	03100	INTENSIVE CARE UNIT	0	33,229	4,283		1,826,739	31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0		0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	14,793	0		2,973,358	50.00
51.00	05100	RECOVERY ROOM	0	3,397	0		435,160	51.00
53.00	05300	ANESTHESIOLOGY	0	2,814	0		31,542	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	192,321	0		3,535,781	54.00
54.01	03630	ULTRA SOUND	0	0	0		0	54.01
56.00	05600	RADIOISOTOPE	0	0	0		0	56.00
57.00	05700	CT SCAN	0	0	0		0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	558	0		130,121	59.00
60.00	06000	LABORATORY	0	117,242	0		1,771,461	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	1,897	0		69,951	62.00
65.00	06500	RESPIRATORY THERAPY	0	29,275	0		615,389	65.00
66.00	06600	PHYSICAL THERAPY	0	3,659	0		525,183	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	3,119	0		207,736	67.00
68.00	06800	SPEECH PATHOLOGY	0	249	0		75,898	68.00
69.00	06900	ELECTROCARDIOLOGY	0	7,393	0		98,683	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	11,676	0		76,351	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,290	0		3,407	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	331,878	89,040	0		716,627	73.00
76.00	03950	MISC ANCILLARY	0	0	0		0	76.00
76.01	03951	SLEEP LAB	0	0	0		0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0		0	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	789	0		146,038	90.00
91.00	09100	EMERGENCY	0	141,405	0		3,323,460	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	331,878	718,751	19,731	0	25,245,695	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		68,761	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0		26	192.00
194.00	07950	MEALS ON WHEELS	0	0	0		0	194.00
200.00		Cross Foot Adjustments				1,928	1,928	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	331,878	718,751	19,731	1,928	25,316,410	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0047 | Period: From 06/01/2021 To 05/31/2022 | Worksheet B Part II | Date/Time Prepared: 10/28/2022 2:52 pm

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			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
5.01	00590	REVENUE CYCLE				5.01
5.02	00560	PURCHASING RECEIVING AND STORES				5.02
5.03	00591	ADMINISTRATIVE AND GENERAL				5.03
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE				17.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV				22.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	8,682,810		30.00
31.00	03100	INTENSIVE CARE UNIT	0	1,826,739		31.00
44.00	04400	SKILLED NURSING FACILITY	0	0		44.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	2,973,358		50.00
51.00	05100	RECOVERY ROOM	0	435,160		51.00
53.00	05300	ANESTHESIOLOGY	0	31,542		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,535,781		54.00
54.01	03630	ULTRA SOUND	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	130,121		59.00
60.00	06000	LABORATORY	0	1,771,461		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	69,951		62.00
65.00	06500	RESPIRATORY THERAPY	0	615,389		65.00
66.00	06600	PHYSICAL THERAPY	0	525,183		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	207,736		67.00
68.00	06800	SPEECH PATHOLOGY	0	75,898		68.00
69.00	06900	ELECTROCARDIOLOGY	0	98,683		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	76,351		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	3,407		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	716,627		73.00
76.00	03950	MISC ANCILLARY	0	0		76.00
76.01	03951	SLEEP LAB	0	0		76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0		76.02
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	146,038		90.00
91.00	09100	EMERGENCY	0	3,323,460		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0			92.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	25,245,695		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	68,761		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	26		192.00
194.00	07950	MEALS ON WHEELS	0	0		194.00
200.00		Cross Foot Adjustments	0	1,928		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	0	25,316,410		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0047 | Period: From 06/01/2021 To 05/31/2022 | Worksheet B-1 | Date/Time Prepared: 10/28/2022 2:52 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FOO TAGE)	MVBLE EQUIP (SQUARE FOO TAGE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	REVENUE CYCLE (GROSS CHAR GES)	PURCHASING RECEIVING AND STORES (COSTED REQUIS.)	
			1.00	2.00	4.00	5.01	5.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	278,658					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		278,658				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,966	1,966	17,325,044			4.00
5.01	00590	REVENUE CYCLE	6,975	6,975	892,758	218,901,752		5.01
5.02	00560	PURCHASING RECEIVING AND STORES	4,844	4,844	17,462	0	2,625,922	5.02
5.03	00591	ADMINISTRATIVE AND GENERAL	18,286	18,286	2,287,231	0	203,992	5.03
7.00	00700	OPERATION OF PLANT	80,660	80,660	945,358	0	13,959	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,544	1,544	0	0	0	8.00
9.00	00900	HOUSEKEEPING	23,373	23,373	469,269	0	74,192	9.00
10.00	01000	DIETARY	10,907	10,907	495	0	530,831	10.00
11.00	01100	CAFETERIA	2,365	2,365	123	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	2,675	2,675	1,581,138	0	3,880	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	198,812	0	88,821	14.00
15.00	01500	PHARMACY	1,733	1,733	643,595	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,375	4,375	3,061	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	242,075	0	0	17.00
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	38,364	38,364	3,362,168	19,678,607	156,487	30.00
31.00	03100	INTENSIVE CARE UNIT	7,717	7,717	768,114	10,121,591	70,960	31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	17,317	17,317	405,084	4,505,856	174,683	50.00
51.00	05100	RECOVERY ROOM	2,423	2,423	157,994	1,034,876	2,454	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	857,065	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	18,395	18,395	1,136,498	58,551,173	0	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	765	765	45,181	169,992	0	59.00
60.00	06000	LABORATORY	7,768	7,768	1,256,956	35,711,893	590,445	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	322	322	0	577,905	60,979	62.00
65.00	06500	RESPIRATORY THERAPY	2,974	2,974	699,382	8,917,097	52,678	65.00
66.00	06600	PHYSICAL THERAPY	3,103	3,103	145,621	1,114,520	2,347	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,188	1,188	99,900	950,126	0	67.00
68.00	06800	SPEECH PATHOLOGY	458	458	8,414	75,731	0	68.00
69.00	06900	ELECTROCARDIOLOGY	435	435	158,153	2,252,056	1,195	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	3,556,501	233,103	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	393,067	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,029	1,029	0	27,121,500	0	73.00
76.00	03950	MISC ANCILLARY	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	886	886	0	240,297	0	90.00
91.00	09100	EMERGENCY	15,389	15,389	1,800,202	43,071,899	364,916	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	278,236	278,236	17,325,044	218,901,752	2,625,922	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	422	422	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	MEALS ON WHEELS	0	0	0	0	0	194.00
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)	11,701,082	13,615,328	4,008,266	5,760,108	518,707	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	41.990835	48.860352	0.231357	0.026314	0.197533	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			178,613	642,891	440,264	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.010310	0.002937	0.167661	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: 15-0047 | Period: From 06/01/2021 To 05/31/2022 | Worksheet B-1 | Date/Time Prepared: 10/28/2022 2:52 pm

		Cost Center Description	Reconciliation	ADMINISTRATIVE AND GENERAL (ACCUM.COST)	OPERATION OF PLANT (SQUARE FOOTAGE)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FOOTAGE)	
			5A.03	5.03	7.00	8.00	9.00	
		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
5.01	00590	REVENUE CYCLE						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00591	ADMINISTRATIVE AND GENERAL	-13,046,929	61,315,646				5.03
7.00	00700	OPERATION OF PLANT	0	11,157,272	165,927			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	254,677	1,544	145,168		8.00
9.00	00900	HOUSEKEEPING	0	2,987,890	23,373	0	141,010	9.00
10.00	01000	DIETARY	0	1,765,685	10,907	0	10,907	10.00
11.00	01100	CAFETERIA	0	849,574	2,365	0	2,365	11.00
13.00	01300	NURSING ADMINISTRATION	0	2,317,558	2,675	0	2,675	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	203,916	0	0	0	14.00
15.00	01500	PHARMACY	0	1,138,503	1,733	0	1,733	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	600,460	4,375	0	4,375	16.00
17.00	01700	SOCIAL SERVICE	0	349,377	0	0	0	17.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	68,774	0	0	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	9,250,002	38,364	38,552	38,364	30.00
31.00	03100	INTENSIVE CARE UNIT	0	4,171,140	7,717	23,843	7,717	31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	3,164,805	17,317	6,821	17,317	50.00
51.00	05100	RECOVERY ROOM	0	682,330	2,423	0	2,423	51.00
53.00	05300	ANESTHESIOLOGY	0	934,856	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	4,750,726	18,395	22,847	18,395	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	130,415	765	0	765	59.00
60.00	06000	LABORATORY	0	4,308,081	7,768	0	7,768	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	117,556	322	0	322	62.00
65.00	06500	RESPIRATORY THERAPY	0	1,481,780	2,974	0	2,974	65.00
66.00	06600	PHYSICAL THERAPY	0	504,812	3,103	0	3,103	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	263,756	1,188	0	1,188	67.00
68.00	06800	SPEECH PATHOLOGY	0	54,648	458	0	458	68.00
69.00	06900	ELECTROCARDIOLOGY	0	305,775	435	105	435	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	377,887	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	34,330	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,819,287	1,029	0	1,029	73.00
76.00	03950	MISC ANCILLARY	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	86,817	886	0	886	90.00
91.00	09100	EMERGENCY	0	7,144,618	15,389	52,983	15,389	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-13,046,929	61,277,307	165,505	145,151	140,588	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	38,339	422	0	422	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	17	0	192.00
194.00	07950	MEALS ON WHEELS	0	0	0	0	0	194.00
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)		13,046,929	13,531,352	434,781	5,529,731	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)		0.212783	81.550031	2.995020	39.215169	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		1,719,087	7,652,943	218,627	3,302,531	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.028037	46.122349	1.506027	23.420545	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: 15-0047 | Period: From 06/01/2021 To 05/31/2022 | Worksheet B-1 | Date/Time Prepared: 10/28/2022 2:52 pm

		Cost Center Description	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (GROSS SALARIES)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
			10.00	11.00	13.00	14.00	15.00	
		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
5.01	00590	REVENUE CYCLE						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00591	ADMINISTRATIVE AND GENERAL						5.03
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	34,035					10.00
11.00	01100	CAFETERIA	0	15,118				11.00
13.00	01300	NURSING ADMINISTRATION	0	1,455	5,274,929			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	403	0	1,710,247		14.00
15.00	01500	PHARMACY	0	576	0	0	1,099,662	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	6	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	279	0	0	0	17.00
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	29,422	3,931	2,622,961	156,487	0	30.00
31.00	03100	INTENSIVE CARE UNIT	4,613	733	693,235	70,960	0	31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	370	211,443	174,683	0	50.00
51.00	05100	RECOVERY ROOM	0	172	137,050	2,454	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,517	12,403	0	0	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	84	0	0	0	59.00
60.00	06000	LABORATORY	0	2,217	0	590,445	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	60,979	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	911	0	52,678	0	65.00
66.00	06600	PHYSICAL THERAPY	0	167	0	2,347	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	107	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	13	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	162	0	1,195	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	233,103	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,099,662	73.00
76.00	03950	MISC ANCILLARY	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	2,015	1,597,837	364,916	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	34,035	15,118	5,274,929	1,710,247	1,099,662	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	MEALS ON WHEELS	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	3,458,579	1,315,959	3,260,394	282,385	1,640,181	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	101.618305	87.045839	0.618092	0.165114	1.491532	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	1,887,928	403,153	549,784	33,406	331,878	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	55.470192	26.667086	0.104226	0.019533	0.301800	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: 15-0047 | Period: From 06/01/2021 To 05/31/2022 | Worksheet B-1 | Date/Time Prepared: 10/28/2022 2:52 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TOTAL PATIENT DAYS)	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS APPRV (ROTATIONS)		
			16.00	17.00	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
5.01	00590	REVENUE CYCLE					5.01
5.02	00560	PURCHASING RECEIVING AND STORES					5.02
5.03	00591	ADMINISTRATIVE AND GENERAL					5.03
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	218,901,752				16.00
17.00	01700	SOCIAL SERVICE	0	7,430			17.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	100		22.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	19,678,607	5,817	100		30.00
31.00	03100	INTENSIVE CARE UNIT	10,121,591	1,613	0		31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0		44.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	4,505,856	0	0		50.00
51.00	05100	RECOVERY ROOM	1,034,876	0	0		51.00
53.00	05300	ANESTHESIOLOGY	857,065	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	58,551,173	0	0		54.00
54.01	03630	ULTRA SOUND	0	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0	0		56.00
57.00	05700	CT SCAN	0	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	169,992	0	0		59.00
60.00	06000	LABORATORY	35,711,893	0	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	577,905	0	0		62.00
65.00	06500	RESPIRATORY THERAPY	8,917,097	0	0		65.00
66.00	06600	PHYSICAL THERAPY	1,114,520	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	950,126	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	75,731	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	2,252,056	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,556,501	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	393,067	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	27,121,500	0	0		73.00
76.00	03950	MISC ANCILLARY	0	0	0		76.00
76.01	03951	SLEEP LAB	0	0	0		76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0		76.02
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	240,297	0	0		90.00
91.00	09100	EMERGENCY	43,071,899	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
		SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	218,901,752	7,430	100		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0		192.00
194.00	07950	MEALS ON WHEELS	0	0	0		194.00
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)	1,257,097	448,004	83,408		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.005743	60.296635	834.080000		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	718,751	19,731	1,928		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.003283	2.655585	19.280000		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: 15-0047 | Period: From 06/01/2021 To 05/31/2022 | Worksheet C Part I Date/Time Prepared: 10/28/2022 2:52 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	21,409,567		21,409,567	0	21,409,567	30.00
31.00	03100	INTENSIVE CARE UNIT	7,190,198		7,190,198	0	7,190,198	31.00
44.00	04400	SKILLED NURSING FACILITY	0		0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,167,560		6,167,560	0	6,167,560	50.00
51.00	05100	RECOVERY ROOM	1,226,162		1,226,162	0	1,226,162	51.00
53.00	05300	ANESTHESIOLOGY	1,138,699		1,138,699	0	1,138,699	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,527,422		8,527,422	0	8,527,422	54.00
54.01	03630	ULTRA SOUND	0		0	0	0	54.01
56.00	05600	RADIOISOTOPE	0		0	0	0	56.00
57.00	05700	CT SCAN	0		0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0		0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	258,839		258,839	0	258,839	59.00
60.00	06000	LABORATORY	6,658,435		6,658,435	0	6,658,435	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	194,843		194,843	0	194,843	62.00
65.00	06500	RESPIRATORY THERAPY	2,295,442	0	2,295,442	0	2,295,442	65.00
66.00	06600	PHYSICAL THERAPY	1,008,288	0	1,008,288	0	1,008,288	66.00
67.00	06700	OCCUPATIONAL THERAPY	478,119	0	478,119	0	478,119	67.00
68.00	06800	SPEECH PATHOLOGY	123,154	0	123,154	0	123,154	68.00
69.00	06900	ELECTROCARDIOLOGY	450,918		450,918	0	450,918	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	517,209		517,209	0	517,209	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	43,892		43,892	0	43,892	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,126,607		4,126,607	0	4,126,607	73.00
76.00	03950	MISC ANCILLARY	0		0	0	0	76.00
76.01	03951	SLEEP LAB	0		0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0		0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	213,668		213,668	0	213,668	90.00
91.00	09100	EMERGENCY	12,152,634		12,152,634	0	12,152,634	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,514,184		2,514,184		2,514,184	92.00
200.00		Subtotal (see instructions)	76,695,840	0	76,695,840	0	76,695,840	200.00
201.00		Less Observation Beds	2,514,184		2,514,184		2,514,184	201.00
202.00		Total (see instructions)	74,181,656	0	74,181,656	0	74,181,656	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0047 | Period: From 06/01/2021 To 05/31/2022 | Worksheet C Part I Date/Time Prepared: 10/28/2022 2:52 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	17,009,364		17,009,364			30.00
31.00	03100	INTENSIVE CARE UNIT	10,121,591		10,121,591			31.00
44.00	04400	SKILLED NURSING FACILITY	0		0			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,941,717	2,564,139	4,505,856	1.368788	0.000000	50.00
51.00	05100	RECOVERY ROOM	291,533	743,343	1,034,876	1.184840	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	342,419	514,646	857,065	1.328603	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,095,758	48,455,415	58,551,173	0.145640	0.000000	54.00
54.01	03630	ULTRA SOUND	0	0	0	0.000000	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0.000000	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	18,403	151,589	169,992	1.522654	0.000000	59.00
60.00	06000	LABORATORY	11,009,052	24,702,841	35,711,893	0.186449	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	411,063	166,842	577,905	0.337154	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	7,208,739	1,708,358	8,917,097	0.257420	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,041,430	73,090	1,114,520	0.904684	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	899,614	50,512	950,126	0.503216	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	71,567	4,164	75,731	1.626203	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	519,639	1,732,417	2,252,056	0.200225	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,667,826	1,888,675	3,556,501	0.145426	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	231,200	161,867	393,067	0.111665	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	17,756,817	9,364,683	27,121,500	0.152153	0.000000	73.00
76.00	03950	MISC ANCILLARY	0	0	0	0.000000	0.000000	76.00
76.01	03951	SLEEP LAB	0	0	0	0.000000	0.000000	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0.000000	0.000000	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	18,062	222,235	240,297	0.889183	0.000000	90.00
91.00	09100	EMERGENCY	4,520,536	38,551,363	43,071,899	0.282148	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	417,916	2,251,327	2,669,243	0.941909	0.000000	92.00
200.00		Subtotal (see instructions)	85,594,246	133,307,506	218,901,752			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	85,594,246	133,307,506	218,901,752			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0047 | Period: From 06/01/2021 To 05/31/2022 | Worksheet C Part I Date/Time Prepared: 10/28/2022 2:52 pm

Title XVIII | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio
			11.00
		INPATIENT ROUTINE SERVICE COST CENTERS	
30.00	03000	ADULTS & PEDIATRICS	
31.00	03100	INTENSIVE CARE UNIT	
44.00	04400	SKILLED NURSING FACILITY	
		ANCILLARY SERVICE COST CENTERS	
50.00	05000	OPERATING ROOM	1.368788
51.00	05100	RECOVERY ROOM	1.184840
53.00	05300	ANESTHESIOLOGY	1.328603
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.145640
54.01	03630	ULTRA SOUND	0.000000
56.00	05600	RADIOISOTOPE	0.000000
57.00	05700	CT SCAN	0.000000
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000
59.00	05900	CARDIAC CATHETERIZATION	1.522654
60.00	06000	LABORATORY	0.186449
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.337154
65.00	06500	RESPIRATORY THERAPY	0.257420
66.00	06600	PHYSICAL THERAPY	0.904684
67.00	06700	OCCUPATIONAL THERAPY	0.503216
68.00	06800	SPEECH PATHOLOGY	1.626203
69.00	06900	ELECTROCARDIOLOGY	0.200225
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.145426
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.111665
73.00	07300	DRUGS CHARGED TO PATIENTS	0.152153
76.00	03950	MISC ANCILLARY	0.000000
76.01	03951	SLEEP LAB	0.000000
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000
		OUTPATIENT SERVICE COST CENTERS	
90.00	09000	CLINIC	0.889183
91.00	09100	EMERGENCY	0.282148
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.941909
200.00		Subtotal (see instructions)	
201.00		Less Observation Beds	
202.00		Total (see instructions)	

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0047 | Period: From 06/01/2021 To 05/31/2022 | Worksheet C Part I Date/Time Prepared: 10/28/2022 2:52 pm

Title XIX | 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	21,409,567		21,409,567	0	21,409,567	30.00
31.00	03100	INTENSIVE CARE UNIT	7,190,198		7,190,198	0	7,190,198	31.00
44.00	04400	SKILLED NURSING FACILITY	0		0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,167,560		6,167,560	0	6,167,560	50.00
51.00	05100	RECOVERY ROOM	1,226,162		1,226,162	0	1,226,162	51.00
53.00	05300	ANESTHESIOLOGY	1,138,699		1,138,699	0	1,138,699	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,527,422		8,527,422	0	8,527,422	54.00
54.01	03630	ULTRA SOUND	0		0	0	0	54.01
56.00	05600	RADIOISOTOPE	0		0	0	0	56.00
57.00	05700	CT SCAN	0		0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0		0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	258,839		258,839	0	258,839	59.00
60.00	06000	LABORATORY	6,658,435		6,658,435	0	6,658,435	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	194,843		194,843	0	194,843	62.00
65.00	06500	RESPIRATORY THERAPY	2,295,442	0	2,295,442	0	2,295,442	65.00
66.00	06600	PHYSICAL THERAPY	1,008,288	0	1,008,288	0	1,008,288	66.00
67.00	06700	OCCUPATIONAL THERAPY	478,119	0	478,119	0	478,119	67.00
68.00	06800	SPEECH PATHOLOGY	123,154	0	123,154	0	123,154	68.00
69.00	06900	ELECTROCARDIOLOGY	450,918		450,918	0	450,918	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	517,209		517,209	0	517,209	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	43,892		43,892	0	43,892	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,126,607		4,126,607	0	4,126,607	73.00
76.00	03950	MISC ANCILLARY	0		0	0	0	76.00
76.01	03951	SLEEP LAB	0		0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0		0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	213,668		213,668	0	213,668	90.00
91.00	09100	EMERGENCY	12,152,634		12,152,634	0	12,152,634	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,514,184		2,514,184		2,514,184	92.00
200.00		Subtotal (see instructions)	76,695,840	0	76,695,840	0	76,695,840	200.00
201.00		Less Observation Beds	2,514,184		2,514,184		2,514,184	201.00
202.00		Total (see instructions)	74,181,656	0	74,181,656	0	74,181,656	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0047 | Period: From 06/01/2021 To 05/31/2022 | Worksheet C Part I Date/Time Prepared: 10/28/2022 2:52 pm

Title XIX | Hospital | PPS

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	17,009,364		17,009,364			30.00
31.00	03100	INTENSIVE CARE UNIT	10,121,591		10,121,591			31.00
44.00	04400	SKILLED NURSING FACILITY	0		0			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,941,717	2,564,139	4,505,856	1.368788	0.000000	50.00
51.00	05100	RECOVERY ROOM	291,533	743,343	1,034,876	1.184840	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	342,419	514,646	857,065	1.328603	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,095,758	48,455,415	58,551,173	0.145640	0.000000	54.00
54.01	03630	ULTRA SOUND	0	0	0	0.000000	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0.000000	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	18,403	151,589	169,992	1.522654	0.000000	59.00
60.00	06000	LABORATORY	11,009,052	24,702,841	35,711,893	0.186449	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	411,063	166,842	577,905	0.337154	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	7,208,739	1,708,358	8,917,097	0.257420	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,041,430	73,090	1,114,520	0.904684	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	899,614	50,512	950,126	0.503216	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	71,567	4,164	75,731	1.626203	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	519,639	1,732,417	2,252,056	0.200225	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,667,826	1,888,675	3,556,501	0.145426	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	231,200	161,867	393,067	0.111665	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	17,756,817	9,364,683	27,121,500	0.152153	0.000000	73.00
76.00	03950	MISC ANCILLARY	0	0	0	0.000000	0.000000	76.00
76.01	03951	SLEEP LAB	0	0	0	0.000000	0.000000	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0.000000	0.000000	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	18,062	222,235	240,297	0.889183	0.000000	90.00
91.00	09100	EMERGENCY	4,520,536	38,551,363	43,071,899	0.282148	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	417,916	2,251,327	2,669,243	0.941909	0.000000	92.00
200.00		Subtotal (see instructions)	85,594,246	133,307,506	218,901,752			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	85,594,246	133,307,506	218,901,752			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0047 | Period: From 06/01/2021 To 05/31/2022 | Worksheet C Part I Date/Time Prepared: 10/28/2022 2:52 pm

Title XIX | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
44.00	04400	SKILLED NURSING FACILITY		44.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	1.368788	50.00
51.00	05100	RECOVERY ROOM	1.184840	51.00
53.00	05300	ANESTHESIOLOGY	1.328603	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.145640	54.00
54.01	03630	ULTRA SOUND	0.000000	54.01
56.00	05600	RADIOISOTOPE	0.000000	56.00
57.00	05700	CT SCAN	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	1.522654	59.00
60.00	06000	LABORATORY	0.186449	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.337154	62.00
65.00	06500	RESPIRATORY THERAPY	0.257420	65.00
66.00	06600	PHYSICAL THERAPY	0.904684	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.503216	67.00
68.00	06800	SPEECH PATHOLOGY	1.626203	68.00
69.00	06900	ELECTROCARDIOLOGY	0.200225	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.145426	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.111665	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.152153	73.00
76.00	03950	MISC ANCILLARY	0.000000	76.00
76.01	03951	SLEEP LAB	0.000000	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	76.02
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	0.889183	90.00
91.00	09100	EMERGENCY	0.282148	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.941909	92.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

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

Provider CCN: 15-0047 | Period: From 06/01/2021 To 05/31/2022 | Worksheet C Part II Date/Time Prepared: 10/28/2022 2:52 pm

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,167,560	2,973,358	3,194,202	0	0	50.00
51.00	05100	RECOVERY ROOM	1,226,162	435,160	791,002	0	0	51.00
53.00	05300	ANESTHESIOLOGY	1,138,699	31,542	1,107,157	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,527,422	3,535,781	4,991,641	0	0	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	258,839	130,121	128,718	0	0	59.00
60.00	06000	LABORATORY	6,658,435	1,771,461	4,886,974	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	194,843	69,951	124,892	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	2,295,442	615,389	1,680,053	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,008,288	525,183	483,105	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	478,119	207,736	270,383	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	123,154	75,898	47,256	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	450,918	98,683	352,235	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	517,209	76,351	440,858	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	43,892	3,407	40,485	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,126,607	716,627	3,409,980	0	0	73.00
76.00	03950	MISC ANCILLARY	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	213,668	146,038	67,630	0	0	90.00
91.00	09100	EMERGENCY	12,152,634	3,323,460	8,829,174	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,514,184	1,019,645	1,494,539	0	0	92.00
200.00		Subtotal (sum of lines 50 thru 199)	48,096,075	15,755,791	32,340,284	0	0	200.00
201.00		Less Observation Beds	2,514,184	1,019,645	1,494,539	0	0	201.00
202.00		Total (line 200 minus line 201)	45,581,891	14,736,146	30,845,745	0	0	202.00

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

Provider CCN: 15-0047 | Period: From 06/01/2021 To 05/31/2022 | Worksheet C Part II Date/Time Prepared: 10/28/2022 2:52 pm

Title XIX | Hospital | PPS

		Cost Center Description	Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)		
			6.00	7.00	8.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	6,167,560	4,505,856	1.368788		50.00
51.00	05100	RECOVERY ROOM	1,226,162	1,034,876	1.184840		51.00
53.00	05300	ANESTHESIOLOGY	1,138,699	857,065	1.328603		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,527,422	58,551,173	0.145640		54.00
54.01	03630	ULTRA SOUND	0	0	0.000000		54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000		56.00
57.00	05700	CT SCAN	0	0	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	258,839	169,992	1.522654		59.00
60.00	06000	LABORATORY	6,658,435	35,711,893	0.186449		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	194,843	577,905	0.337154		62.00
65.00	06500	RESPIRATORY THERAPY	2,295,442	8,917,097	0.257420		65.00
66.00	06600	PHYSICAL THERAPY	1,008,288	1,114,520	0.904684		66.00
67.00	06700	OCCUPATIONAL THERAPY	478,119	950,126	0.503216		67.00
68.00	06800	SPEECH PATHOLOGY	123,154	75,731	1.626203		68.00
69.00	06900	ELECTROCARDIOLOGY	450,918	2,252,056	0.200225		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	517,209	3,556,501	0.145426		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	43,892	393,067	0.111665		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,126,607	27,121,500	0.152153		73.00
76.00	03950	MISC ANCILLARY	0	0	0.000000		76.00
76.01	03951	SLEEP LAB	0	0	0.000000		76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0.000000		76.02
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	213,668	240,297	0.889183		90.00
91.00	09100	EMERGENCY	12,152,634	43,071,899	0.282148		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,514,184	2,669,243	0.941909		92.00
200.00		Subtotal (sum of lines 50 thru 199)	48,096,075	191,770,797			200.00
201.00		Less Observation Beds	2,514,184	0			201.00
202.00		Total (line 200 minus line 201)	45,581,891	191,770,797			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-0047 | Period: From 06/01/2021 To 05/31/2022 | Worksheet D Part I Date/Time Prepared: 10/28/2022 2:52 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	8,682,810	0	8,682,810	6,591	1,317.37	30.00
31.00	INTENSIVE CARE UNIT	1,826,739		1,826,739	1,613	1,132.51	31.00
44.00	SKILLED NURSING FACILITY	0		0	0	0.00	44.00
200.00	Total (lines 30 through 199)	10,509,549		10,509,549	8,204		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	892	1,175,094				30.00
31.00	INTENSIVE CARE UNIT	196	221,972				31.00
44.00	SKILLED NURSING FACILITY	0	0				44.00
200.00	Total (lines 30 through 199)	1,088	1,397,066				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-0047 | Period: From 06/01/2021 To 05/31/2022 | Worksheet D Part II Date/Time Prepared: 10/28/2022 2:52 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,973,358	4,505,856	0.659887	304,031	200,626	50.00
51.00	05100	RECOVERY ROOM	435,160	1,034,876	0.420495	25,435	10,695	51.00
53.00	05300	ANESTHESIOLOGY	31,542	857,065	0.036802	51,631	1,900	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,535,781	58,551,173	0.060388	1,739,846	105,066	54.00
54.01	03630	ULTRA SOUND	0	0	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000	0	0	56.00
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	130,121	169,992	0.765454	0	0	59.00
60.00	06000	LABORATORY	1,771,461	35,711,893	0.049604	1,646,745	81,685	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	69,951	577,905	0.121042	44,485	5,385	62.00
65.00	06500	RESPIRATORY THERAPY	615,389	8,917,097	0.069012	1,015,088	70,053	65.00
66.00	06600	PHYSICAL THERAPY	525,183	1,114,520	0.471219	172,216	81,151	66.00
67.00	06700	OCCUPATIONAL THERAPY	207,736	950,126	0.218640	154,362	33,750	67.00
68.00	06800	SPEECH PATHOLOGY	75,898	75,731	1.002205	18,922	18,964	68.00
69.00	06900	ELECTROCARDIOLOGY	98,683	2,252,056	0.043819	78,215	3,427	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	76,351	3,556,501	0.021468	233,468	5,012	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,407	393,067	0.008668	71,950	624	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	716,627	27,121,500	0.026423	2,362,267	62,418	73.00
76.00	03950	MISC ANCILLARY	0	0	0.000000	0	0	76.00
76.01	03951	SLEEP LAB	0	0	0.000000	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0.000000	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	146,038	240,297	0.607740	0	0	90.00
91.00	09100	EMERGENCY	3,323,460	43,071,899	0.077161	594,196	45,849	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,019,645	2,669,243	0.381998	89,737	34,279	92.00
200.00		Total (lines 50 through 199)	15,755,791	191,770,797		8,602,594	760,884	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0047 | Period: From 06/01/2021 To 05/31/2022 | Worksheet D Part III Date/Time Prepared: 10/28/2022 2:52 pm

Title XVIII | Hospital | PPS

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

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	6,591	0.00	892	30.00
31.00	03100	INTENSIVE CARE UNIT		0	1,613	0.00	196	31.00
44.00	04400	SKILLED NURSING FACILITY		0	0	0.00	0	44.00
200.00		Total (lines 30 through 199)		0	8,204		1,088	200.00

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

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0047 | Period: From 06/01/2021 To 05/31/2022 | Worksheet D Part IV Date/Time Prepared: 10/28/2022 2:52 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	MISC ANCILLARY	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0047 | Period: From 06/01/2021 To 05/31/2022 | Worksheet D Part IV Date/Time Prepared: 10/28/2022 2:52 pm

Title XVIII | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	4,505,856	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	1,034,876	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	857,065	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	58,551,173	0.000000	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	169,992	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	35,711,893	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	577,905	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	8,917,097	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,114,520	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	950,126	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	75,731	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	2,252,056	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	3,556,501	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	393,067	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	27,121,500	0.000000	73.00
76.00	03950	MISC ANCILLARY	0	0	0	0	0.000000	76.00
76.01	03951	SLEEP LAB	0	0	0	0	0.000000	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0.000000	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	240,297	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	43,071,899	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	2,669,243	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	191,770,797		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0047 | Period: From 06/01/2021 To 05/31/2022 | Worksheet D Part IV Date/Time Prepared: 10/28/2022 2:52 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	304,031	0	165,260	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	25,435	0	70,072	0	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	51,631	0	41,189	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	1,739,846	0	4,534,310	0	54.00
54.01	03630	ULTRA SOUND	0.000000	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	15,986	0	59.00
60.00	06000	LABORATORY	0.000000	1,646,745	0	975,141	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	44,485	0	28,128	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.000000	1,015,088	0	201,869	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	172,216	0	2,932	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	154,362	0	491	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	18,922	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	78,215	0	155,556	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	233,468	0	63,383	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	71,950	0	2,289	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	2,362,267	0	695,417	0	73.00
76.00	03950	MISC ANCILLARY	0.000000	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0.000000	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	43,772	0	90.00
91.00	09100	EMERGENCY	0.000000	594,196	0	2,105,260	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	89,737	0	174,644	0	92.00
200.00		Total (lines 50 through 199)		8,602,594	0	9,275,699	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0047 | Period: From 06/01/2021 To 05/31/2022 | Worksheet D Part V Date/Time Prepared: 10/28/2022 2:52 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1.368788	165,260	0	0	226,206	50.00
51.00	05100	RECOVERY ROOM	1.184840	70,072	0	0	83,024	51.00
53.00	05300	ANESTHESIOLOGY	1.328603	41,189	0	0	54,724	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.145640	4,534,310	0	0	660,377	54.00
54.01	03630	ULTRA SOUND	0.000000	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	1.522654	15,986	0	0	24,341	59.00
60.00	06000	LABORATORY	0.186449	975,141	2,750	0	181,814	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.337154	28,128	0	0	9,483	62.00
65.00	06500	RESPIRATORY THERAPY	0.257420	201,869	0	0	51,965	65.00
66.00	06600	PHYSICAL THERAPY	0.904684	2,932	0	0	2,653	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.503216	491	0	0	247	67.00
68.00	06800	SPEECH PATHOLOGY	1.626203	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.200225	155,556	0	0	31,146	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.145426	63,383	0	0	9,218	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.111665	2,289	0	0	256	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.152153	695,417	0	17,399	105,810	73.00
76.00	03950	MISC ANCILLARY	0.000000	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0.000000	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.889183	43,772	0	0	38,921	90.00
91.00	09100	EMERGENCY	0.282148	2,105,260	0	0	593,995	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.941909	174,644	0	0	164,499	92.00
200.00		Subtotal (see instructions)		9,275,699	2,750	17,399	2,238,679	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		9,275,699	2,750	17,399	2,238,679	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0047 | Period: From 06/01/2021 To 05/31/2022 | Worksheet D Part V Date/Time Prepared: 10/28/2022 2:52 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
54.01	03630	ULTRA SOUND	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	56.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	513	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,647	73.00
76.00	03950	MISC ANCILLARY	0	0	76.00
76.01	03951	SLEEP LAB	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
200.00		Subtotal (see instructions)	513	2,647	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	513	2,647	202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-0047 | Period: From 06/01/2021 To 05/31/2022 | Worksheet D Part I Date/Time Prepared: 10/28/2022 2:52 pm

Title XIX | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	8,682,810	0	8,682,810	6,591	1,317.37	30.00
31.00	INTENSIVE CARE UNIT	1,826,739		1,826,739	1,613	1,132.51	31.00
44.00	SKILLED NURSING FACILITY	0		0	0	0.00	44.00
200.00	Total (lines 30 through 199)	10,509,549		10,509,549	8,204		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	467	615,212				30.00
31.00	INTENSIVE CARE UNIT	80	90,601				31.00
44.00	SKILLED NURSING FACILITY	0	0				44.00
200.00	Total (lines 30 through 199)	547	705,813				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-0047 | Period: From 06/01/2021 To 05/31/2022 | Worksheet D Part II Date/Time Prepared: 10/28/2022 2:52 pm

Title XIX | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,973,358	4,505,856	0.659887	174,999	115,480	50.00
51.00	05100	RECOVERY ROOM	435,160	1,034,876	0.420495	22,740	9,562	51.00
53.00	05300	ANESTHESIOLOGY	31,542	857,065	0.036802	32,742	1,205	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,535,781	58,551,173	0.060388	707,507	42,725	54.00
54.01	03630	ULTRA SOUND	0	0	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000	0	0	56.00
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	130,121	169,992	0.765454	0	0	59.00
60.00	06000	LABORATORY	1,771,461	35,711,893	0.049604	824,789	40,913	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	69,951	577,905	0.121042	48,618	5,885	62.00
65.00	06500	RESPIRATORY THERAPY	615,389	8,917,097	0.069012	430,114	29,683	65.00
66.00	06600	PHYSICAL THERAPY	525,183	1,114,520	0.471219	51,784	24,402	66.00
67.00	06700	OCCUPATIONAL THERAPY	207,736	950,126	0.218640	47,136	10,306	67.00
68.00	06800	SPEECH PATHOLOGY	75,898	75,731	1.002205	3,579	3,587	68.00
69.00	06900	ELECTROCARDIOLOGY	98,683	2,252,056	0.043819	37,431	1,640	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	76,351	3,556,501	0.021468	132,480	2,844	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,407	393,067	0.008668	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	716,627	27,121,500	0.026423	1,546,094	40,852	73.00
76.00	03950	MISC ANCILLARY	0	0	0.000000	0	0	76.00
76.01	03951	SLEEP LAB	0	0	0.000000	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0.000000	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	146,038	240,297	0.607740	1,055	641	90.00
91.00	09100	EMERGENCY	3,323,460	43,071,899	0.077161	352,394	27,191	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,019,645	2,669,243	0.381998	29,768	11,371	92.00
200.00		Total (lines 50 through 199)	15,755,791	191,770,797		4,443,230	368,287	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0047 | Period: From 06/01/2021 To 05/31/2022 | Worksheet D Part III Date/Time Prepared: 10/28/2022 2:52 pm

Title XIX | Hospital | PPS

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

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	6,591	0.00	467	30.00
31.00	03100	INTENSIVE CARE UNIT		0	1,613	0.00	80	31.00
44.00	04400	SKILLED NURSING FACILITY		0	0	0.00	0	44.00
200.00		Total (lines 30 through 199)		0	8,204		547	200.00

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

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0047 | Period: From 06/01/2021 To 05/31/2022 | Worksheet D Part IV Date/Time Prepared: 10/28/2022 2:52 pm

Title XIX | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	MISC ANCILLARY	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0047 | Period: From 06/01/2021 To 05/31/2022 | Worksheet D Part IV Date/Time Prepared: 10/28/2022 2:52 pm

Title XIX | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	4,505,856	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	1,034,876	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	857,065	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	58,551,173	0.000000	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	169,992	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	35,711,893	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	577,905	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	8,917,097	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,114,520	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	950,126	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	75,731	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	2,252,056	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	3,556,501	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	393,067	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	27,121,500	0.000000	73.00
76.00	03950	MISC ANCILLARY	0	0	0	0	0.000000	76.00
76.01	03951	SLEEP LAB	0	0	0	0	0.000000	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0.000000	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	240,297	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	43,071,899	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	2,669,243	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	191,770,797		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0047 | Period: From 06/01/2021 To 05/31/2022 | Worksheet D Part IV | Date/Time Prepared: 10/28/2022 2:52 pm

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		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	174,999	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	22,740	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	32,742	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	707,507	0	0	0	54.00
54.01	03630	ULTRA SOUND	0.000000	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	824,789	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	48,618	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.000000	430,114	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	51,784	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	47,136	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	3,579	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	37,431	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	132,480	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	1,546,094	0	0	0	73.00
76.00	03950	MISC ANCILLARY	0.000000	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0.000000	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	1,055	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	352,394	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	29,768	0	0	0	92.00
200.00		Total (lines 50 through 199)		4,443,230	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0047 | Period: From 06/01/2021 To 05/31/2022 | Worksheet D Part V Date/Time Prepared: 10/28/2022 2:52 pm

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		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1.368788	0	0	60,992	0	50.00
51.00	05100	RECOVERY ROOM	1.184840	0	0	6,592	0	51.00
53.00	05300	ANESTHESIOLOGY	1.328603	0	0	11,096	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.145640	0	0	2,992,731	0	54.00
54.01	03630	ULTRA SOUND	0.000000	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	1.522654	0	0	2,588	0	59.00
60.00	06000	LABORATORY	0.186449	0	0	1,085,171	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.337154	0	0	16,448	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.257420	0	0	220,940	0	65.00
66.00	06600	PHYSICAL THERAPY	0.904684	0	0	5,895	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.503216	0	0	2,640	0	67.00
68.00	06800	SPEECH PATHOLOGY	1.626203	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.200225	0	0	83,149	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.145426	0	0	54,262	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.111665	0	0	832	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.152153	0	0	504,920	0	73.00
76.00	03950	MISC ANCILLARY	0.000000	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0.000000	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.889183	0	0	6,748	0	90.00
91.00	09100	EMERGENCY	0.282148	0	0	2,065,024	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.941909	0	0	130,385	0	92.00
200.00		Subtotal (see instructions)		0	0	7,250,413	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	0	7,250,413	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0047 | Period: From 06/01/2021 To 05/31/2022 | Worksheet D Part V Date/Time Prepared: 10/28/2022 2:52 pm

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		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	83,485		50.00
51.00	05100	RECOVERY ROOM	0	7,810		51.00
53.00	05300	ANESTHESIOLOGY	0	14,742		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	435,861		54.00
54.01	03630	ULTRA SOUND	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	3,941		59.00
60.00	06000	LABORATORY	0	202,329		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	5,546		62.00
65.00	06500	RESPIRATORY THERAPY	0	56,874		65.00
66.00	06600	PHYSICAL THERAPY	0	5,333		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,328		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	16,649		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	7,891		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	93		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	76,825		73.00
76.00	03950	MISC ANCILLARY	0	0		76.00
76.01	03951	SLEEP LAB	0	0		76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0		76.02
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	6,000		90.00
91.00	09100	EMERGENCY	0	582,642		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	122,811		92.00
200.00		Subtotal (see instructions)	0	1,630,160		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	1,630,160		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0047 | Period: From 06/01/2021 To 05/31/2022 | Worksheet D-1 | Date/Time Prepared: 10/28/2022 2:52 pm

Title XVIII | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	6,865	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	6,591	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)	5,817	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)	274	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)	892	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)	89	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)	21,409,567	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)	21,409,567	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)	21,409,567	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)	3,248.30	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,897,484	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	2,897,484	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0047 | Period: From 06/01/2021 To 05/31/2022 | Worksheet D-1 | Date/Time Prepared: 10/28/2022 2:52 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	7,190,198	1,613	4,457.66	196	873,701	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)	2,285,111	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	6,056,296	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	1,397,066	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	760,884	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	2,157,950	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	3,898,346	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)	774	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	3,248.30	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	2,514,184	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0047 | Period: From 06/01/2021 To 05/31/2022 | Worksheet D-1 | Date/Time Prepared: 10/28/2022 2:52 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	8,682,810	21,409,567	0.405557	2,514,184	1,019,645	90.00
91.00	Nursing Program cost	0	21,409,567	0.000000	2,514,184	0	91.00
92.00	Allied health cost	0	21,409,567	0.000000	2,514,184	0	92.00
93.00	All other Medical Education	0	21,409,567	0.000000	2,514,184	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0047 | Period: From 06/01/2021 To 05/31/2022 | Worksheet D-1 | Date/Time Prepared: 10/28/2022 2:52 pm

Title XIX | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	6,865	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	6,591	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)	5,817	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)	274	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)	467	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)	21,409,567	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)	21,409,567	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)	21,409,567	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)	3,248.30	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,516,956	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)	1,516,956	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0047 | Period: From 06/01/2021 To 05/31/2022 | Worksheet D-1 | Date/Time Prepared: 10/28/2022 2:52 pm

Title XIX | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	7,190,198	1,613	4,457.66	80	356,613	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	1,160,711	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	3,034,280	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)	705,813	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	368,287	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	1,074,100	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	1,960,180	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)	774	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	3,248.30	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	2,514,184	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0047 | Period: From 06/01/2021 To 05/31/2022 | Worksheet D-1 | Date/Time Prepared: 10/28/2022 2:52 pm

Title XIX | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	8,682,810	21,409,567	0.405557	2,514,184	1,019,645	90.00
91.00	Nursing Program cost	0	21,409,567	0.000000	2,514,184	0	91.00
92.00	Allied health cost	0	21,409,567	0.000000	2,514,184	0	92.00
93.00	All other Medical Education	0	21,409,567	0.000000	2,514,184	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0047 | Period: From 06/01/2021 To 05/31/2022 | Worksheet D-3 | Date/Time Prepared: 10/28/2022 2:52 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		2,670,906		30.00
31.00	03100	INTENSIVE CARE UNIT		1,094,040		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	1.368788	304,031	416,154	50.00
51.00	05100	RECOVERY ROOM	1.184840	25,435	30,136	51.00
53.00	05300	ANESTHESIOLOGY	1.328603	51,631	68,597	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.145640	1,739,846	253,391	54.00
54.01	03630	ULTRA SOUND	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	1.522654	0	0	59.00
60.00	06000	LABORATORY	0.186449	1,646,745	307,034	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.337154	44,485	14,998	62.00
65.00	06500	RESPIRATORY THERAPY	0.257420	1,015,088	261,304	65.00
66.00	06600	PHYSICAL THERAPY	0.904684	172,216	155,801	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.503216	154,362	77,677	67.00
68.00	06800	SPEECH PATHOLOGY	1.626203	18,922	30,771	68.00
69.00	06900	ELECTROCARDIOLOGY	0.200225	78,215	15,661	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.145426	233,468	33,952	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.111665	71,950	8,034	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.152153	2,362,267	359,426	73.00
76.00	03950	MISC ANCILLARY	0.000000	0	0	76.00
76.01	03951	SLEEP LAB	0.000000	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.889183	0	0	90.00
91.00	09100	EMERGENCY	0.282148	594,196	167,651	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.941909	89,737	84,524	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		8,602,594	2,285,111	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)		8,602,594		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-0047 | Component CCN: 15-U047 | Period: From 06/01/2021 To 05/31/2022 | Worksheet D-3 | Date/Time Prepared: 10/28/2022 2:52 pm

Title XVIII | Swing Beds - SNF | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	1.368788	0	0	50.00
51.00	05100	RECOVERY ROOM	1.184840	0	0	51.00
53.00	05300	ANESTHESIOLOGY	1.328603	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.145640	5,856	853	54.00
54.01	03630	ULTRA SOUND	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	1.522654	0	0	59.00
60.00	06000	LABORATORY	0.186449	35,770	6,669	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.337154	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.257420	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.904684	49,835	45,085	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.503216	62,532	31,467	67.00
68.00	06800	SPEECH PATHOLOGY	1.626203	5,584	9,081	68.00
69.00	06900	ELECTROCARDIOLOGY	0.200225	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.145426	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.111665	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.152153	51,434	7,826	73.00
76.00	03950	MISC ANCILLARY	0.000000	0	0	76.00
76.01	03951	SLEEP LAB	0.000000	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.889183	0	0	90.00
91.00	09100	EMERGENCY	0.282148	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.941909	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		211,011	100,981	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)		211,011		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0047 | Period: From 06/01/2021 To 05/31/2022 | Worksheet D-3 | Date/Time Prepared: 10/28/2022 2:52 pm

Title XIX | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		1,362,840		30.00
31.00	03100	INTENSIVE CARE UNIT		664,905		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	1.368788	174,999	239,537	50.00
51.00	05100	RECOVERY ROOM	1.184840	22,740	26,943	51.00
53.00	05300	ANESTHESIOLOGY	1.328603	32,742	43,501	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.145640	707,507	103,041	54.00
54.01	03630	ULTRA SOUND	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	1.522654	0	0	59.00
60.00	06000	LABORATORY	0.186449	824,789	153,781	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.337154	48,618	16,392	62.00
65.00	06500	RESPIRATORY THERAPY	0.257420	430,114	110,720	65.00
66.00	06600	PHYSICAL THERAPY	0.904684	51,784	46,848	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.503216	47,136	23,720	67.00
68.00	06800	SPEECH PATHOLOGY	1.626203	3,579	5,820	68.00
69.00	06900	ELECTROCARDIOLOGY	0.200225	37,431	7,495	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.145426	132,480	19,266	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.111665	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.152153	1,546,094	235,243	73.00
76.00	03950	MISC ANCILLARY	0.000000	0	0	76.00
76.01	03951	SLEEP LAB	0.000000	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.889183	1,055	938	90.00
91.00	09100	EMERGENCY	0.282148	352,394	99,427	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.941909	29,768	28,039	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		4,443,230	1,160,711	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		4,443,230		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

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Title XIX | Swing Beds - SNF | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	1.368788	0	0	50.00
51.00	05100	RECOVERY ROOM	1.184840	0	0	51.00
53.00	05300	ANESTHESIOLOGY	1.328603	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.145640	0	0	54.00
54.01	03630	ULTRA SOUND	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	1.522654	0	0	59.00
60.00	06000	LABORATORY	0.186449	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.337154	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.257420	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.904684	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.503216	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1.626203	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.200225	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.145426	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.111665	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.152153	0	0	73.00
76.00	03950	MISC ANCILLARY	0.000000	0	0	76.00
76.01	03951	SLEEP LAB	0.000000	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.889183	0	0	90.00
91.00	09100	EMERGENCY	0.282148	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.941909	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		0	0	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)		0		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0047	Period: From 06/01/2021 To 05/31/2022	Worksheet E Part A Date/Time Prepared: 10/28/2022 2:52 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		
1.00	DRG Amounts Other than Outlier Payments	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	537,463	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	1,158,674	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)	0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)	0	1.04
2.00	Outlier payments for discharges. (see instructions)		2.00
2.01	Outlier reconciliation amount	0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)	0	2.02
2.03	Outlier payments for discharges occurring prior to October 1 (see instructions)	1,728	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)	373,629	2.04
3.00	Managed Care Simulated Payments	2,617,404	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	57.55	4.00
	Indirect Medical Education Adjustment		
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)	8.95	5.00
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)	0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.	1.89	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	-6.37	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.	0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)	0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)	0.69	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	0.85	10.00
11.00	FTE count for residents in dental and podiatric programs.	0.00	11.00
12.00	Current year allowable FTE (see instructions)	0.69	12.00
13.00	Total allowable FTE count for the prior year.	0.69	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.	0.42	14.00
15.00	Sum of lines 12 through 14 divided by 3.	0.60	15.00
16.00	Adjustment for residents in initial years of the program	0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure	0.00	17.00
18.00	Adjusted rolling average FTE count	0.60	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.010426	19.00
20.00	Prior year resident to bed ratio (see instructions)	0.011577	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.010426	21.00
22.00	IME payment adjustment (see instructions)	9,641	22.00
22.01	IME payment adjustment - Managed Care (see instructions)	14,877	22.01
	Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA		
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).	4.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)	0.16	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)	0.16	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)	0.002780	26.00
27.00	IME payments adjustment factor. (see instructions)	0.000743	27.00
28.00	IME add-on adjustment amount (see instructions)	1,260	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)	1,945	28.01
29.00	Total IME payment (sum of lines 22 and 28)	10,901	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	16,822	29.01
	Disproportionate Share Adjustment		
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	18.01	30.00
31.00	Percentage of Medicaid patient days (see instructions)	46.04	31.00
32.00	Sum of lines 30 and 31	64.05	32.00
33.00	Allowable disproportionate share percentage (see instructions)	12.00	33.00
34.00	Disproportionate share adjustment (see instructions)	50,884	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0047 | Period: From 06/01/2021 To 05/31/2022 | Worksheet E Part A Date/Time Prepared: 10/28/2022 2:52 pm

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		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	Uncompensated Care Adjustment			
35.00	Total uncompensated care amount (see instructions)	0	0	35.00
35.01	Factor 3 (see instructions)	0.000000000	0.000000000	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	762,335	1,199,923	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	254,808	798,852	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	1,053,660		36.00
	Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)			
40.00	Total Medicare discharges (see instructions)	0		40.00
		Before 1/1	On/After 1/1	
		1.00	1.01	
41.00	Total ESRD Medicare discharges (see instructions)	0	0	41.00
41.01	Total ESRD Medicare covered and paid discharges (see instructions)	0	0	41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days (see instructions)	0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00	0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00
47.00	Subtotal (see instructions)	3,186,939		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	0		48.00
			Amount	
			1.00	
49.00	Total payment for inpatient operating costs (see instructions)		3,203,761	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		262,667	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).		22,506	52.00
53.00	Nursing and Allied Health Managed Care payment		0	53.00
54.00	Special add-on payments for new technologies		131,862	54.00
54.01	Islet isolation add-on payment		0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0	55.00
56.00	Cost of physicians' services in a teaching hospital (see intructions)		0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		0	58.00
59.00	Total (sum of amounts on lines 49 through 58)		3,620,796	59.00
60.00	Primary payer payments		0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		3,620,796	61.00
62.00	Deductibles billed to program beneficiaries		178,784	62.00
63.00	Coinsurance billed to program beneficiaries		12,614	63.00
64.00	Allowable bad debts (see instructions)		86,235	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		56,053	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		19,607	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		3,485,451	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)		0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	70.00
70.50	Rural Community Hospital Demonstration Project (§410A Demonstration) adjustment (see instructions)		0	70.50
70.87	Demonstration payment adjustment amount before sequestration		0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)		0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)			70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		0	70.91
70.92	Bundled Model 1 discount amount (see instructions)		0	70.92
70.93	HVBP payment adjustment amount (see instructions)		-1,671	70.93
70.94	HRR adjustment amount (see instructions)		-129	70.94
70.95	Recovery of accelerated depreciation		0	70.95

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		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		3,483,651	71.00
71.01	Sequestration adjustment (see instructions)		5,922	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
71.03	Sequestration adjustment-PARHM pass-throughs			71.03
72.00	Interim payments		2,756,994	72.00
72.01	Interim payments-PARHM			72.01
73.00	Tentative settlement (for contractor use only)		0	73.00
73.01	Tentative settlement-PARHM (for contractor use only)			73.01
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		720,735	74.00
74.01	Balance due provider/program-PARHM (see instructions)			74.01
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		1,133,712	75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0047 | Period: From 06/01/2021 To 05/31/2022 | Worksheet E Part B Date/Time Prepared: 10/28/2022 2:52 pm

Title XVIII | Hospital | PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	3,160	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	2,238,679	2.00
3.00	OPPS payments	789,991	3.00
4.00	Outlier payment (see instructions)	3,950	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	3,160	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	20,149	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)	20,149	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)	20,149	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	16,989	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	3,160	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)	793,941	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	951	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	137,105	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)	659,045	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	8,242	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)	667,287	30.00
31.00	Primary payer payments	784	31.00
32.00	Subtotal (line 30 minus line 31)	666,503	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)	56,809	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	36,926	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	30,449	36.00
37.00	Subtotal (see instructions)	703,429	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)	703,429	40.00
40.01	Sequestration adjustment (see instructions)	1,196	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	734,226	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)	-31,993	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: 15-0047	Period: From 06/01/2021 To 05/31/2022	Worksheet E Part B Date/Time Prepared: 10/28/2022 2:52 pm
	Title XVIII	Hospital	PPS

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-0047 | Period: From 06/01/2021 To 05/31/2022 | Worksheet E-1 Part I | Date/Time Prepared: 10/28/2022 2:52 pm

Title XVIII | Hospital | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		2,756,994		734,226	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)		2,756,994		734,226	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		720,735		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		31,993	6.02
7.00	Total Medicare program liability (see instructions)		3,477,729		702,233	7.00

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-0047 | Component CCN: 15-U047 | Period: From 06/01/2021 To 05/31/2022 | Worksheet E-1 Part I | Date/Time Prepared: 10/28/2022 2:52 pm

Title XVIII | Swing Beds - SNF | 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		63,129		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		63,129		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		129		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		63,258		0	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-0047	Period: From 06/01/2021 To 05/31/2022	Worksheet E-1 Part II Date/Time Prepared: 10/28/2022 2:52 pm
	Title XVIII	Hospital	PPS

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

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 15-0047 | Component CCN: 15-U047 | Period: From 06/01/2021 To 05/31/2022 | Worksheet E-2 | Date/Time Prepared: 10/28/2022 2:52 pm

Title XVIII | Swing Beds - SNF | PPS

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	63,452	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swing-bed pass-through, see instructions)	0	0	3.00
3.01	Nursing and allied health payment-PARHM (see instructions)			3.01
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	89	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	63,452	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	63,452	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	63,452	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	194	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (see instructions)	63,258	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			16.50
16.55	Rural community hospital demonstration project (§410A Demonstration) payment adjustment (see instructions)	0		16.55
16.99	Demonstration payment adjustment amount before sequestration	0	0	16.99
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	63,258	0	19.00
19.01	Sequestration adjustment (see instructions)	0	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0	0	19.02
19.03	Sequestration adjustment-PARHM pass-throughs			19.03
19.25	Sequestration for non-claims based amounts (see instructions)	0	0	19.25
20.00	Interim payments	63,129	0	20.00
20.01	Interim payments-PARHM			20.01
21.00	Tentative settlement (for contractor use only)	0	0	21.00
21.01	Tentative settlement-PARHM (for contractor use only)			21.01
22.00	Balance due provider/program (line 19 minus lines 19.01, 19.02, 19.25, 20, and 21)	129	0	22.00
22.01	Balance due provider/program-PARHM (see instructions)			22.01
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	23.00
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
	Cost Reimbursement			
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))			201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))			202.00
203.00	Total (sum of lines 201 and 202)			203.00
204.00	Medicare swing-bed SNF discharges (see instructions)			204.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
205.00	Medicare swing-bed SNF target amount			205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)			206.00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)			208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
	Comparision of PPS versus Cost Reimbursement			
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)			215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS | Provider CCN: 15-0047 | Component CCN: 15-U047 | Period: From 06/01/2021 To 05/31/2022 | Worksheet E-2 | Date/Time Prepared: 10/28/2022 2:52 pm

Title XIX | Swing Beds - SNF | PPS

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

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0047 | Period: From 06/01/2021 To 05/31/2022 | Worksheet E-3 Part VII Date/Time Prepared: 10/28/2022 2:52 pm

Title XIX | Hospital | PPS

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	0		1.00
2.00	Medical and other services		1,630,160	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	0	1,630,160	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	0	1,630,160	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	2,027,745		8.00
9.00	Ancillary service charges	4,443,230	7,250,413	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)	6,470,975	7,250,413	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)	6,470,975	7,250,413	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	6,470,975	5,620,253	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	0	1,630,160	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	0	1,630,160	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	0	1,630,160	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	0	1,630,160	36.00
37.00	ELIMINATE SETTLEMENT	0	-1,630,160	37.00
38.00	Subtotal (line 36 ± line 37)	0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	0	0	40.00
41.00	Interim payments	0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS | Provider CCN: 15-0047 | Period: From 06/01/2021 To 05/31/2022 | Worksheet E-4 | Date/Time Prepared: 10/28/2022 2:52 pm

Title XVIII | Hospital | PPS

		1.00	
	COMPUTATION OF TOTAL DIRECT GME AMOUNT		
1.00	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.	7.63	1.00
2.00	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)	0.00	2.00
3.00	Amount of reduction to Direct GME cap under section 422 of MMA	0.00	3.00
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)	0.00	3.01
4.00	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))	-6.94	4.00
4.01	ACA Section 5503 increase to the Direct GME FTE Cap (see instructions for cost reporting periods straddling 7/1/2011)	0.00	4.01
4.02	ACA Section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)	0.00	4.02
5.00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus lines 4.01 and 4.02 plus applicable subscripts	0.69	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)	0.85	6.00
7.00	Enter the lesser of line 5 or line 6	0.69	7.00

		Primary Care	Other	Total	
		1.00	2.00	3.00	
8.00	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year.	0.85	0.00	0.85	8.00
9.00	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6.	0.69	0.00	0.69	9.00
10.00	Weighted dental and podiatric resident FTE count for the current year		0.00		10.00
10.01	Unweighted dental and podiatric resident FTE count for the current year		0.00		10.01
11.00	Total weighted FTE count	0.69	0.00		11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	0.69	0.00		12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	0.42	0.00		13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	0.60	0.00		14.00
15.00	Adjustment for residents in initial years of new programs	0.00	0.00		15.00
15.01	Unweighted adjustment for residents in initial years of new programs	0.00	0.00		15.01
16.00	Adjustment for residents displaced by program or hospital closure	0.00	0.00		16.00
16.01	Unweighted adjustment for residents displaced by program or hospital closure	0.00	0.00		16.01
17.00	Adjusted rolling average FTE count	0.60	0.00		17.00
18.00	Per resident amount	112,988.94	106,990.60		18.00
19.00	Approved amount for resident costs	67,793	0	67,793	19.00

		1.00	
20.00	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 Sec. 413.79(c)(4)	5.00	20.00
21.00	Direct GME FTE unweighted resident count over cap (see instructions)	0.16	21.00
22.00	Allowable additional direct GME FTE Resident Count (see instructions)	0.16	22.00
23.00	Enter the locality adjustment national average per resident amount (see instructions)	112,364.43	23.00
24.00	Multiply line 22 time line 23	17,978	24.00
25.00	Total direct GME amount (sum of lines 19 and 24)	85,771	25.00

		Inpatient Part A	Managed Care Prior to 1/1	Managed Care On or after 1/1	Total	
		1.00	2.00	2.01	3.00	
	COMPUTATION OF PROGRAM PATIENT LOAD					
26.00	Inpatient Days (see instructions) (Title XIX - see S-2 Part IX, line 3.02, column 2)	1,088	378	1,250		26.00
27.00	Total Inpatient Days (see instructions)	7,430	7,430	7,430		27.00
28.00	Ratio of inpatient days to total inpatient days	0.146433	0.050875	0.168237		28.00
29.00	Program direct GME amount	12,560	4,364	14,430	31,354	29.00
29.01	Percent reduction for MA DGME		3.22	3.22		29.01
30.00	Reduction for direct GME payments for Medicare Advantage		141	465	606	30.00
31.00	Net Program direct GME amount				30,748	31.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS | Provider CCN: 15-0047 | Period: From 06/01/2021 To 05/31/2022 | Worksheet E-4 | Date/Time Prepared: 10/28/2022 2:52 pm

Title XVIII | Hospital | PPS

		1.00	
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING PROGRAM AND PARAMEDICAL EDUCATION COSTS)		
32.00	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)	0	32.00
33.00	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)	0	33.00
34.00	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)	0.000000	34.00
35.00	Medicare outpatient ESRD charges (see instructions)	0	35.00
36.00	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)	0	36.00
	APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY		
	Part A Reasonable Cost		
37.00	Reasonable cost (see instructions)	6,119,748	37.00
38.00	Organ acquisition costs (Wkst. D-4, Pt. III, col. 1, line 69)	0	38.00
39.00	Cost of physicians' services in a teaching hospital (see instructions)	0	39.00
40.00	Primary payer payments (see instructions)	0	40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)	6,119,748	41.00
	Part B Reasonable Cost		
42.00	Reasonable cost (see instructions)	2,241,839	42.00
43.00	Primary payer payments (see instructions)	784	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)	2,241,055	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)	8,360,803	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)	0.731957	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)	0.268043	47.00
	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B		
48.00	Total program GME payment (line 31)	30,748	48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)	22,506	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)	8,242	50.00

		Y/N	Primary Care	Other	Total	
		0	1.00	2.00	3.00	
	E-4 Calculation - In accordance with the FY 2023 IPPS Final Rule.					
109.00	Enter in column 0, "Y" or "N" to calculate line 9 in accordance the Federal Fiscal Year 2023 Final Rule for cost reporting periods beginning prior to 10/1/2021. (see instructions)	N	0.00	0.00	0.00	109.00

If line 109 column 0 is Y, you MUST open up the PY and Penultimate cost reports and answer line 109 column 0 "Y" and calculate, then input amounts from line 11 columns 1 & 2 to the CY lines 12 & 13 columns 1 & 2 respectively.

122.00	Override of line 22 for cost reporting periods beginning prior to 10/1/2021. (see instructions)		0.00			122.00

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

Provider CCN: 15-0047 | Period: From 06/01/2021 To 05/31/2022 | Worksheet G | Date/Time Prepared: 10/28/2022 2:52 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	-308,341	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	8,401,082	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-4,130,990	0	0	0	6.00
7.00	Inventory	2,096,534	0	0	0	7.00
8.00	Prepaid expenses	758,707	0	0	0	8.00
9.00	Other current assets	825,476	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)	7,642,468	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	1,010,000	0	0	0	12.00
13.00	Land improvements	395,750	0	0	0	13.00
14.00	Accumulated depreciation	-316,600	0	0	0	14.00
15.00	Buildings	87,011,356	0	0	0	15.00
16.00	Accumulated depreciation	-3,232,479	0	0	0	16.00
17.00	Leasehold improvements	282,623	0	0	0	17.00
18.00	Accumulated depreciation	-69,622	0	0	0	18.00
19.00	Fixed equipment	1,098,238	0	0	0	19.00
20.00	Accumulated depreciation	-104,536	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	22,198,367	0	0	0	23.00
24.00	Accumulated depreciation	-4,313,349	0	0	0	24.00
25.00	Minor equipment depreciable	3,401,404	0	0	0	25.00
26.00	Accumulated depreciation	-610,884	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)	106,750,268	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	14,504,541	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	14,504,541	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	128,897,277	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	2,705,876	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,402,059	0	0	0	38.00
39.00	Payroll taxes payable	-1,844	0	0	0	39.00
40.00	Notes and loans payable (short term)	332,995	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	172,174,495	0	0	0	43.00
44.00	Other current liabilities	4,074,676	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	180,688,257	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	1,233,643	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	783,142	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	2,016,785	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	182,705,042	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	-53,807,765				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)	-53,807,765	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	128,897,277	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-0047 | Period: From 06/01/2021 To 05/31/2022 | Worksheet G-1 | Date/Time Prepared: 10/28/2022 2:52 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		-31,603,517		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-22,204,248				2.00
3.00	Total (sum of line 1 and line 2)		-53,807,765		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)		-53,807,765		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		-53,807,765		0		19.00

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 15-0047 | Period: From 06/01/2021 To 05/31/2022 | Worksheet G-2 Parts I & II | Date/Time Prepared: 10/28/2022 2:52 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	17,009,364		17,009,364	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	0		0	7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	17,009,364		17,009,364	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	10,121,591		10,121,591	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)	10,121,591		10,121,591	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	27,130,955		27,130,955	17.00
18.00	Ancillary services	53,506,778	92,282,581	145,789,359	18.00
19.00	Outpatient services	4,956,514	41,024,925	45,981,439	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	IP CONTRACTED HOSPICE	122,532	0	122,532	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	85,716,779	133,307,506	219,024,285	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		72,866,739		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)		72,866,739		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-0047 | Period: From 06/01/2021 To 05/31/2022 | Worksheet G-3 | Date/Time Prepared: 10/28/2022 2:52 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	219,024,285	1.00
2.00	Less contractual allowances and discounts on patients' accounts	173,334,998	2.00
3.00	Net patient revenues (line 1 minus line 2)	45,689,287	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	72,866,739	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-27,177,452	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	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 MISC GAIN/LOSS	4,648,134	24.00
24.50	COVID-19 PHE Funding	325,070	24.50
25.00	Total other income (sum of lines 6-24)	4,973,204	25.00
26.00	Total (line 5 plus line 25)	-22,204,248	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)	-22,204,248	29.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 15-0047	Period: From 06/01/2021 To 05/31/2022	Worksheet L Parts I-III Date/Time Prepared: 10/28/2022 2:52 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	126,704	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	134,620	2.00
2.01	Model 4 BPCI Capital DRG outlier payments	0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)	20.43	3.00
4.00	Number of interns & residents (see instructions)	0.76	4.00
5.00	Indirect medical education percentage (see instructions)	1.06	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)	1,343	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	0.00	8.00
9.00	Sum of lines 7 and 8	0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)	0.00	10.00
11.00	Disproportionate share adjustment (see instructions)	0	11.00
12.00	Total prospective capital payments (see instructions)	262,667	12.00
		1.00	
	PART II - PAYMENT UNDER REASONABLE COST		
1.00	Program inpatient routine capital cost (see instructions)	0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)	0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)	0	3.00
4.00	Capital cost payment factor (see instructions)	0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)	0	5.00
		1.00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS		
1.00	Program inpatient capital costs (see instructions)	0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)	0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)	0	3.00
4.00	Applicable exception percentage (see instructions)	0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)	0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)	0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)	0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)	0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)	0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)	0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)	0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)	0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)	0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)	0	14.00
15.00	Current year allowable operating and capital payment (see instructions)	0	15.00
16.00	Current year operating and capital costs (see instructions)	0	16.00
17.00	Current year exception offset amount (see instructions)	0	17.00