This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g).

FORM APPROVED
OMB NO. 0938-0050
EXPIRES 09-30-2025

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 15-0149	Period: From 01/01/2022 To 12/31/2022	Worksheet S Parts I-III Date/Time Prepared: 5/30/2023 8:21 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 5/30/2023 Time: 8:21 am
2. [ ] Manually prepared cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no.

Contractor use only

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

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

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by DEACONESS WOMENS HOSPITAL (15-0149) for the cost reporting period beginning 01/01/2022 and ending 12/31/2022 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR		CHECKBOX	ELECTRONIC SIGNATURE STATEMENT	
	1		2		
1	Christina Ryan		Y	I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name	Christina Ryan			2
3	Signatory Title	CEO			3
4	Date	(Dated when report is electronica			4

		Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	HOSPITAL	0	-39,763	11,243	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	0	0		0	5.00
6.00	SWING BED - NF	0				0	6.00
200.00	TOTAL	0	-39,763	11,243	0	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0149 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-2 Part I Date/Time Prepared: 5/30/2023 8:21 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 4199 GATEWAY BLVD	PO Box:			1.00
2.00	City: NEWBURGH	State: IN	Zip Code: 47630-8940	County: WARRICK	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	DEACONESS WOMENS HOSPITAL	150149	21780	1	05/03/2001	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									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2022	12/31/2022	20.00
21.00	Type of Control (see instructions)	6		21.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0149 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-2 Part I | Date/Time Prepared: 5/30/2023 8:21 am

		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.	1,151	1,259	122	241	8,837	160	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)	N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? For cost reporting periods beginning prior to December 27, 2020, enter "Y" for yes or "N" for no in column 1. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.78(b)(2), see the instructions. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2.	N			56.00
57.00	For cost reporting periods beginning prior to December 27, 2020, if line 56, column 1, is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.77(e)(1)(iv) and (v), regardless of which month(s) of the cost report the residents were on duty, if the response to line 56 is "Y" for yes, enter "Y" for yes in column 1, do not complete column 2, and complete Worksheet E-4.				57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.				58.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0149 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-2 Part I Date/Time Prepared: 5/30/2023 8:21 am

		V	XVIII	XIX	
		1.00	2.00	3.00	
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0149 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-2 Part I Date/Time Prepared: 5/30/2023 8:21 am

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0149 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-2 Part I Date/Time Prepared: 5/30/2023 8:21 am

				1.00	
	Direct GME in Accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022)				
68.00	For a cost reporting period beginning prior to October 1, 2022, did you obtain permission from your MAC to apply the new DGME formula in accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022)?			N	68.00

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

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

		Approved for Permanent Adjustment (Y/N)	Number of Approved Permanent Adjustments	
		1.00	2.00	
88.00	Column 1: Is this hospital approved for a permanent adjustment to the TEFRA target amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete col. 2 and line 89. (see instructions) Column 2: Enter the number of approved permanent adjustments.		0	88.00

		Wkst. A Line No.	Effective Date	Approved Permanent Adjustment Amount Per Discharge	
		1.00	2.00	3.00	
89.00	Column 1: If line 88, column 1 is Y, enter the Worksheet A line number on which the per discharge permanent adjustment approval was based. Column 2: Enter the effective date (i.e., the cost reporting period beginning date) for the permanent adjustment to the TEFRA target amount per discharge. Column 3: Enter the amount of the approved permanent adjustment to the TEFRA target amount per discharge.	0.00		0	89.00

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0149 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-2 Part I Date/Time Prepared: 5/30/2023 8:21 am

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0149 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-2 Part I | Date/Time Prepared: 5/30/2023 8:21 am

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	370,822	16,011	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
123.00	Did the facility and/or its subproviders (if applicable) purchase professional services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, and/or management/consulting services, from an unrelated organization? In column 1, enter "Y" for yes or "N" for no. If column 1 is "Y", were the majority of the expenses, i.e., greater than 50% of total professional services expenses, for services purchased from unrelated organizations located in a CBSA outside of the main hospital CBSA? In column 2, enter "Y" for yes or "N" for no.	Y	Y	123.00
	Certified Transplant Center Information			
125.00	Does this facility operate a Medicare-certified transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare-certified kidney transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare-certified heart transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare-certified liver transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare-certified lung transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare-certified pancreas transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare-certified intestinal transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare-certified islet transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is a hospital-based organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	HB0778	140.00

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name: DEACONESS HEALTH SYSTEM	Contractor's Name: WPS	Contractor's Number: 08001	141.00
142.00	Street: 600 MARY ST	PO Box:		142.00
143.00	City: EVANSVILLE	State: IN	Zip Code: 47710	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0149 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-2 Part I Date/Time Prepared: 5/30/2023 8:21 am

					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: 15-0149 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-2 Part II | Date/Time Prepared: 5/30/2023 8:21 am

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

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

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

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	N		N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	05/15/2023	Y	05/15/2023	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-0149 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-2 Part II Date/Time Prepared: 5/30/2023 8:21 am

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

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

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?	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	09/30/2022	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.	DANIELLE	METZGER-CUNDIFF	41.00
42.00	Enter the employer/company name of the cost report preparer.	DEACONESS HOSPITAL, INC		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	(812) 450-7423	DANIELLE.METZGER-CUNDIFF@DEACONESS.C	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-0149	Period: From 01/01/2022 To 12/31/2022	Worksheet S-2 Part II Date/Time Prepared: 5/30/2023 8:21 am

		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	REIMBURSEMENT ANALYST		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: 15-0149 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-3 Part I Date/Time Prepared: 5/30/2023 8:21 am

	Component	Worksheet A Line No.	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	50	18,250	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)		50	18,250	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	24	8,760	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		74	27,010	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		74				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care	30.00	0	0		0	34.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-0149 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-3 Part I | Date/Time Prepared: 5/30/2023 8:21 am

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	126	550	8,226			1.00
2.00	HMO and other (see instructions)	39	8,837				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	126	550	8,226			7.00
8.00	INTENSIVE CARE UNIT	0	1,761	9,386			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		462	5,303			13.00
14.00	Total (see instructions)	126	2,773	22,915	0.00	575.92	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	575.92	27.00
28.00	Observation Bed Days		48	1,922			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	160	390			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care	0	0	0			34.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-0149 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-3 Part I | Date/Time Prepared: 5/30/2023 8:21 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	50	269	3,628	1.00
2.00	HMO and other (see instructions)			15	1,249		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	50	269	3,628	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care						34.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0149 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-3 Part II Date/Time Prepared: 5/30/2023 8:21 am

		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	52,561,403	-459,372	52,102,031	1,197,908.96	43.49	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		1,336,430	125,000	1,461,430	7,820.60	186.87	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		7,763,230	0	7,763,230	48,052.10	161.56	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		4,925,569	581,720	5,507,289	103,888.38	53.01	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		0	0	0	0.00	0.00	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		1,776,111	0	1,776,111	8,511.30	208.68	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		2,948,806	0	2,948,806	78,440.00	37.59	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)		10,258,016	0	10,258,016			17.00
18.00	Wage-related costs (other) (see instructions)							18.00
19.00	Excluded areas		1,514,785	0	1,514,785			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		183,116	0	183,116			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		855,218	0	855,218			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)		849,973	0	849,973			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: 15-0149 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-3 Part II Date/Time Prepared: 5/30/2023 8:21 am

		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	381,561	12,563	394,124	9,716.59	40.56	26.00
27.00	Administrative & General	5.00	7,327,761	-782,485	6,545,276	150,263.42	43.56	27.00
28.00	Administrative & General under contract (see inst.)		188,519	0	188,519	537.04	351.03	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	448,376	-4,148	444,228	20,100.04	22.10	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	1,026,409	-8,801	1,017,608	53,392.82	19.06	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	0	236,696	236,696	9,402.10	25.17	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	1,168,259	-616,586	551,673	31,770.94	17.36	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	0	0	0	0.00	0.00	38.00
39.00	Central Services and Supply	14.00	145,595	-7,066	138,529	5,785.39	23.94	39.00
40.00	Pharmacy	15.00	0	0	0	0.00	0.00	40.00
41.00	Medical Records & Medical Records Library	16.00	458,755	-1,373	457,382	19,188.18	23.84	41.00
42.00	Social Service	17.00	490,354	-5,888	484,466	14,516.79	33.37	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0149 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-3 Part III Date/Time Prepared: 5/30/2023 8:21 am

		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)		44,986,692	-459,372	44,527,320	1,150,393.90	38.71	1.00
2.00	Excluded area salaries (see instructions)		4,925,569	581,720	5,507,289	103,888.38	53.01	2.00
3.00	Subtotal salaries (line 1 minus line 2)		40,061,123	-1,041,092	39,020,031	1,046,505.52	37.29	3.00
4.00	Subtotal other wages & related costs (see inst.)		4,724,917	0	4,724,917	86,951.30	54.34	4.00
5.00	Subtotal wage-related costs (see inst.)		11,291,105	0	11,291,105	0.00	28.94	5.00
6.00	Total (sum of lines 3 thru 5)		56,077,145	-1,041,092	55,036,053	1,133,456.82	48.56	6.00
7.00	Total overhead cost (see instructions)		11,635,589	-1,177,088	10,458,501	314,673.31	33.24	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 15-0149 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-3 Part IV Date/Time Prepared: 5/30/2023 8:21 am

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	1,161,637	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)	6,336,260	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	287,677	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	39,460	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)	1,010,383	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	169,123	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Noncumulative portion)	0	16.00
	TAXES		
17.00	FICA-Employers Portion Only	3,563,576	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	80,336	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	57,678	21.00
22.00	Day Care Cost and Allowances	32,556	22.00
23.00	Tuition Reimbursement	72,450	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	12,811,136	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: 15-0149 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-3 Part V Date/Time Prepared: 5/30/2023 8:21 am

	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	0	12,811,136	1.00
2.00	Hospital	0	12,811,136	2.00
3.00	SUBPROVIDER - IPF			3.00
4.00	SUBPROVIDER - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	SKILLED NURSING FACILITY			8.00
9.00	NURSING FACILITY			9.00
10.00	OTHER LONG TERM CARE I			10.00
11.00	Hospital-Based HHA			11.00
12.00	AMBULATORY SURGICAL CENTER (D.P.) I			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	RENAL DIALYSIS I			17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-0149 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-10 | Date/Time Prepared: 5/30/2023 8:21 am

		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)	0.438971	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	17,478,619	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?	N	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	6,381,317	5.00
6.00	Medicaid charges	62,479,500	6.00
7.00	Medicaid cost (line 1 times line 6)	27,426,689	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)	3,566,753	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)	3,566,753	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)	682,390	173,929	856,319	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	299,549	173,929	473,478	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	299,549	173,929	473,478	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)	2,352,540	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	25,737	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	39,594	27.01
28.00	Non-Medicare bad debt expense (see instructions)	2,312,946	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	1,029,173	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,502,651	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	5,069,404	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0149 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A | Date/Time Prepared: 5/30/2023 8:21 am

		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		0	0	5,152,736	5,152,736	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	2,870,568	2,870,568	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	381,561	11,760,255	12,141,816	12,563	12,154,379	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	7,327,761	19,147,817	26,475,578	-6,147,179	20,328,399	5.00
7.00	00700	OPERATION OF PLANT	448,376	1,729,882	2,178,258	-115,678	2,062,580	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	982,419	982,419	8.00
9.00	00900	HOUSEKEEPING	1,026,409	1,318,213	2,344,622	-1,007,268	1,337,354	9.00
10.00	01000	DIETARY	0	0	0	368,585	368,585	10.00
11.00	01100	CAFETERIA	1,168,259	671,380	1,839,639	-980,569	859,070	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	145,595	73,627	219,222	-19,934	199,288	14.00
15.00	01500	PHARMACY	0	4,262,424	4,262,424	-2,912,897	1,349,527	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	458,755	50,839	509,594	0	509,594	16.00
17.00	01700	SOCIAL SERVICE	490,354	11,879	502,233	-203	502,030	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,913,699	1,032,116	10,945,815	-4,726,731	6,219,084	30.00
31.00	03100	INTENSIVE CARE UNIT	8,728,302	1,821,440	10,549,742	-413,344	10,136,398	31.00
43.00	04300	NURSERY	1,069,538	145,129	1,214,667	-102,162	1,112,505	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,573,258	9,772,605	14,345,863	-9,181,065	5,164,798	50.00
51.00	05100	RECOVERY ROOM	654,835	11,200	666,035	-8,841	657,194	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	4,111,901	4,111,901	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,492,312	1,296,497	3,788,809	-838,535	2,950,274	54.00
57.00	05700	CT SCAN	0	0	0	107,371	107,371	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	108,603	108,603	58.00
60.00	06000	LABORATORY	0	3,367,476	3,367,476	-57,125	3,310,351	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	38,491	38,491	63.00
65.00	06500	RESPIRATORY THERAPY	1,537,563	675,087	2,212,650	-302,447	1,910,203	65.00
66.00	06600	PHYSICAL THERAPY	0	2,959,203	2,959,203	-189,616	2,769,587	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	3,749,203	3,749,203	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	678,641	678,641	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	2,820,314	2,820,314	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	5,256,147	974,269	6,230,416	-196,333	6,034,083	90.00
91.00	09100	EMERGENCY	1,963,110	741,928	2,705,038	5,500,535	8,205,573	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	47,635,834	61,823,266	109,459,100	-697,997	108,761,103	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	572,713	572,713	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	4,127,290	646,422	4,773,712	121,620	4,895,332	192.00
194.00	07950	OTHER DEPARTMENTS	0	0	0	0	0	194.00
194.01	07951	WOMEN'S RESOURCES	350,205	182,205	532,410	-6,368	526,042	194.01
194.02	07952	MARKETING	254,081	465,366	719,447	13,587	733,034	194.02
194.03	07953	REPRODUCTIVE MEDICINE	0	710	710	2,413	3,123	194.03
194.04	07954	CENTER FOR HEALING ARTS	193,993	134,572	328,565	-5,968	322,597	194.04
200.00		TOTAL (SUM OF LINES 118 through 199)	52,561,403	63,252,541	115,813,944	0	115,813,944	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0149 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A | Date/Time Prepared: 5/30/2023 8:21 am

		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	52,271	5,205,007		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	2,870,568		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,700,325	15,854,704		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-1,180,758	19,147,641		5.00
7.00	00700	OPERATION OF PLANT	1,456,777	3,519,357		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	982,419		8.00
9.00	00900	HOUSEKEEPING	0	1,337,354		9.00
10.00	01000	DIETARY	0	368,585		10.00
11.00	01100	CAFETERIA	-284,708	574,362		11.00
13.00	01300	NURSING ADMINISTRATION	0	0		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	344,429	543,717		14.00
15.00	01500	PHARMACY	862,639	2,212,166		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	33,736	543,330		16.00
17.00	01700	SOCIAL SERVICE	-121	501,909		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	6,219,084		30.00
31.00	03100	INTENSIVE CARE UNIT	-3,605,281	6,531,117		31.00
43.00	04300	NURSERY	0	1,112,505		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-68,139	5,096,659		50.00
51.00	05100	RECOVERY ROOM	0	657,194		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	4,111,901		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-26,939	2,923,335		54.00
57.00	05700	CT SCAN	0	107,371		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	108,603		58.00
60.00	06000	LABORATORY	-12,000	3,298,351		60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	38,491		63.00
65.00	06500	RESPIRATORY THERAPY	0	1,910,203		65.00
66.00	06600	PHYSICAL THERAPY	-1,221,959	1,547,628		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,749,203		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	678,641		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,820,314		73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0		77.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	-4,029,281	2,004,802		90.00
91.00	09100	EMERGENCY	-5,593,540	2,612,033		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
102.00	10200	OPIOID TREATMENT PROGRAM	0	0		102.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-9,572,549	99,188,554		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	-189,806	382,907		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	4,895,332		192.00
194.00	07950	OTHER DEPARTMENTS	0	0		194.00
194.01	07951	WOMEN'S RESOURCES	-54,333	471,709		194.01
194.02	07952	MARKETING	0	733,034		194.02
194.03	07953	REPRODUCTIVE MEDICINE	0	3,123		194.03
194.04	07954	CENTER FOR HEALING ARTS	-150,341	172,256		194.04
200.00		TOTAL (SUM OF LINES 118 through 199)	-9,967,029	105,846,915		200.00

RECLASSIFICATIONS | Provider CCN: 15-0149 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-6 | Date/Time Prepared: 5/30/2023 8:21 am

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - LEASEHOLD IMPROVEMENTS				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	605,944	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
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
	0		0	605,944	
	B - EQUIPMENT DEPRECIATION				
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	1,616,286	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
	0		0	1,616,286	
	C - INTEREST EXPENSE				
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	234,569	1.00
2.00	REPRODUCTIVE MEDICINE	194.03	0	2,413	2.00
3.00		0.00	0	0	3.00
	0		0	236,982	
	D - EQUIPMENT LEASES				
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	846,820	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
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	846,820	
	E - BUILDING LEASES				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	4,395,512	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
	0		0	4,395,512	
	F - DRUGS/IV SOLUTIONS				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	2,820,314	1.00
2.00		0.00	0	0	2.00
	0		0	2,820,314	
	G - IMPLANTABLE DEVICES				
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	678,641	1.00
2.00		0.00	0	0	2.00
	0		0	678,641	

RECLASSIFICATIONS | Provider CCN: 15-0149 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-6 | Date/Time Prepared: 5/30/2023 8:21 am

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	H - PROPERTY INSURANCE				
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	57,962	1.00
2.00		0.00	0	0	2.00
	0		0	57,962	
	I - DIETARY				
1.00	DIETARY	10.00	236,696	0	1.00
2.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00	367,782	0	2.00
3.00		0.00	0	0	3.00
4.00	DIETARY	10.00	0	131,889	4.00
5.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00	0	204,931	5.00
6.00		0.00	0	0	6.00
	0		604,478	336,820	
	J - PROPERTY TAXES				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	151,280	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	114,931	2.00
3.00		0.00	0	0	3.00
	0		0	266,211	
	K - LABOR & DELIVERY				
1.00	DELIVERY ROOM & LABOR ROOM	52.00	3,925,235	0	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	0	186,666	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
	0		3,925,235	186,666	
	M - EMERGENCY DEPARTMENT				
1.00	EMERGENCY	91.00	912,277	0	1.00
2.00		0.00	0	0	2.00
3.00	EMERGENCY	91.00	0	59,723	3.00
4.00		0.00	0	0	4.00
	0		912,277	59,723	
	N - INCENTIVE COMPENSATION				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	12,563	0	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	137,973	0	2.00
3.00	HOUSEKEEPING	9.00	583	0	3.00
4.00	CAFETERIA	11.00	5,201	0	4.00
5.00	ADULTS & PEDIATRICS	30.00	11,842	0	5.00
6.00	INTENSIVE CARE UNIT	31.00	21,999	0	6.00
7.00	OPERATING ROOM	50.00	14,312	0	7.00
8.00	RECOVERY ROOM	51.00	466	0	8.00
9.00	RADIOLOGY-DIAGNOSTIC	54.00	4,857	0	9.00
10.00	RESPIRATORY THERAPY	65.00	1,283	0	10.00
11.00	CLINIC	90.00	326,430	0	11.00
12.00	PHYSICIANS' PRIVATE OFFICES	192.00	365,610	0	12.00
13.00	WOMEN'S RESOURCES	194.01	140	0	13.00
14.00	MARKETING	194.02	14,262	0	14.00
15.00		0.00	0	0	15.00
	0		917,521	0	
	O - PHYSICIAN PART A				
1.00	ADMINISTRATIVE & GENERAL	5.00	18,500	0	1.00
2.00	OPERATING ROOM	50.00	125,000	0	2.00
3.00		0.00	0	0	3.00
	0		143,500	0	
	P - DISABILITY				
1.00	ADMINISTRATIVE & GENERAL	5.00	0	21,437	1.00
2.00	OPERATION OF PLANT	7.00	0	4,148	2.00
3.00	HOUSEKEEPING	9.00	0	9,384	3.00
4.00	CAFETERIA	11.00	0	17,309	4.00
5.00	CENTRAL SERVICES & SUPPLY	14.00	0	7,066	5.00
6.00	MEDICAL RECORDS & LIBRARY	16.00	0	1,373	6.00
7.00	SOCIAL SERVICE	17.00	0	5,888	7.00
8.00	ADULTS & PEDIATRICS	30.00	0	163,167	8.00
9.00	INTENSIVE CARE UNIT	31.00	0	92,868	9.00
10.00	NURSERY	43.00	0	9,907	10.00
11.00	OPERATING ROOM	50.00	0	35,797	11.00
12.00	RECOVERY ROOM	51.00	0	710	12.00
13.00	RADIOLOGY-DIAGNOSTIC	54.00	0	33,680	13.00
14.00	RESPIRATORY THERAPY	65.00	0	10,039	14.00
15.00	CLINIC	90.00	0	21,558	15.00
16.00	EMERGENCY	91.00	0	2,467	16.00
17.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	19,280	17.00
18.00	WOMEN'S RESOURCES	194.01	0	2,658	18.00
19.00	CENTER FOR HEALING ARTS	194.04	0	636	19.00
20.00		0.00	0	0	20.00

RECLASSIFICATIONS | Provider CCN: 15-0149 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-6 | Date/Time Prepared: 5/30/2023 8:21 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
21.00		0.00	0	0		21.00
22.00		0.00	0	0		22.00
23.00		0.00	0	0		23.00
24.00		0.00	0	0		24.00
25.00		0.00	0	0		25.00
26.00		0.00	0	0		26.00
27.00		0.00	0	0		27.00
28.00		0.00	0	0		28.00
29.00		0.00	0	0		29.00
30.00		0.00	0	0		30.00
31.00		0.00	0	0		31.00
32.00		0.00	0	0		32.00
33.00		0.00	0	0		33.00
34.00		0.00	0	0		34.00
35.00		0.00	0	0		35.00
36.00		0.00	0	0		36.00
37.00		0.00	0	0		37.00
38.00		0.00	0	0		38.00
	0		0	459,372		
	Q - LAUNDRY					
1.00	LAUNDRY & LINEN SERVICE	8.00	0	982,419		1.00
2.00		0.00	0	0		2.00
	0		0	982,419		
	R - MEDICAL SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	4,427,844		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	183,648		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
	0		0	4,611,492		
	S - ANESTHESIA PART A					
1.00	EMERGENCY	91.00	0	4,528,902		1.00
2.00		0.00	0	0		2.00
	0		0	4,528,902		
	T - RADIOLOGY					
1.00	CT SCAN	57.00	88,412	0		1.00
2.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	89,426	0		2.00
3.00		0.00	0	0		3.00
4.00	CT SCAN	57.00	0	18,959		4.00
5.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	19,177		5.00
6.00		0.00	0	0		6.00
	0		177,838	38,136		
	U - BLOOD BANK					
1.00	BLOOD STORING, PROCESSING, & TRANS.	63.00	0	38,491		1.00
2.00		0.00	0	0		2.00
	0		0	38,491		
500.00	Grand Total: Increases		6,680,849	22,766,693		500.00

RECLASSIFICATIONS | Provider CCN: 15-0149 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-6 | Date/Time Prepared: 5/30/2023 8:21 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - LEASEHOLD IMPROVEMENTS						
1.00		0.00	0	0	9		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	258,836	0		2.00
3.00	OPERATION OF PLANT	7.00	0	93,169	0		3.00
4.00	CAFETERIA	11.00	0	13,057	0		4.00
5.00	PHARMACY	15.00	0	6,420	0		5.00
6.00	SOCIAL SERVICE	17.00	0	203	0		6.00
7.00	ADULTS & PEDIATRICS	30.00	0	233	0		7.00
8.00	OPERATING ROOM	50.00	0	4,712	0		8.00
9.00	RADIOLOGY-DIAGNOSTIC	54.00	0	22,790	0		9.00
10.00	PHYSICAL THERAPY	66.00	0	85,355	0		10.00
11.00	CLINIC	90.00	0	120,628	0		11.00
12.00	WOMEN'S RESOURCES	194.01	0	541	0		12.00
	0		0	605,944			
	B - EQUIPMENT DEPRECIATION						
1.00		0.00	0	0	9		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	625,580	0		2.00
3.00	OPERATION OF PLANT	7.00	0	19,807	0		3.00
4.00	HOUSEKEEPING	9.00	0	25,047	0		4.00
5.00	CAFETERIA	11.00	0	31,415	0		5.00
6.00	CENTRAL SERVICES & SUPPLY	14.00	0	19,934	0		6.00
7.00	ADULTS & PEDIATRICS	30.00	0	185,701	0		7.00
8.00	INTENSIVE CARE UNIT	31.00	0	170,511	0		8.00
9.00	NURSERY	43.00	0	14,903	0		9.00
10.00	OPERATING ROOM	50.00	0	111,544	0		10.00
11.00	RECOVERY ROOM	51.00	0	9,114	0		11.00
12.00	RADIOLOGY-DIAGNOSTIC	54.00	0	159,178	0		12.00
13.00	LABORATORY	60.00	0	18,615	0		13.00
14.00	RESPIRATORY THERAPY	65.00	0	88,579	0		14.00
15.00	PHYSICAL THERAPY	66.00	0	18,971	0		15.00
16.00	CLINIC	90.00	0	18,636	0		16.00
17.00	EMERGENCY	91.00	0	367	0		17.00
18.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	92,416	0		18.00
19.00	CENTER FOR HEALING ARTS	194.04	0	5,968	0		19.00
	0		0	1,616,286			
	C - INTEREST EXPENSE						
1.00		0.00	0	0	11		1.00
2.00		0.00	0	0	0		2.00
3.00	ADMINISTRATIVE & GENERAL	5.00	0	236,982	0		3.00
	0		0	236,982			
	D - EQUIPMENT LEASES						
1.00		0.00	0	0	10		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	179,889	0		2.00
3.00	OPERATION OF PLANT	7.00	0	2,702	0		3.00
4.00	HOUSEKEEPING	9.00	0	385	0		4.00
5.00	PHARMACY	15.00	0	86,163	0		5.00
6.00	ADULTS & PEDIATRICS	30.00	0	433	0		6.00
7.00	INTENSIVE CARE UNIT	31.00	0	13,787	0		7.00
8.00	OPERATING ROOM	50.00	0	193,180	0		8.00
9.00	RADIOLOGY-DIAGNOSTIC	54.00	0	108,871	0		9.00
10.00	RESPIRATORY THERAPY	65.00	0	52,711	0		10.00
11.00	CLINIC	90.00	0	202,057	0		11.00
12.00	WOMEN'S RESOURCES	194.01	0	5,967	0		12.00
13.00	MARKETING	194.02	0	675	0		13.00
	0		0	846,820			
	E - BUILDING LEASES						
1.00		0.00	0	0	10		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	3,944,319	0		2.00
3.00	INTENSIVE CARE UNIT	31.00	0	62,052	0		3.00
4.00	RADIOLOGY-DIAGNOSTIC	54.00	0	123,332	0		4.00
5.00	PHYSICAL THERAPY	66.00	0	85,290	0		5.00
6.00	CLINIC	90.00	0	172,445	0		6.00
7.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	8,074	0		7.00
	0		0	4,395,512			
	F - DRUGS/IV SOLUTIONS						
1.00		0.00	0	0	0		1.00
2.00	PHARMACY	15.00	0	2,820,314	0		2.00
	0		0	2,820,314			
	G - IMPLANTABLE DEVICES						
1.00		0.00	0	0	0		1.00
2.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	678,641	0		2.00
	0		0	678,641			

RECLASSIFICATIONS | Provider CCN: 15-0149 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-6 | Date/Time Prepared: 5/30/2023 8:21 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	H - PROPERTY INSURANCE						
1.00		0.00	0	0	12		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	57,962	0		2.00
	0		0	57,962			
	I - DIETARY						
1.00		0.00	0	0	0		1.00
2.00		0.00	0	0	0		2.00
3.00	CAFETERIA	11.00	604,478	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00	CAFETERIA	11.00	0	336,820	0		6.00
	0		604,478	336,820			
	J - PROPERTY TAXES						
1.00		0.00	0	0	13		1.00
2.00		0.00	0	0	13		2.00
3.00	ADMINISTRATIVE & GENERAL	5.00	0	266,211	0		3.00
	0		0	266,211			
	K - LABOR & DELIVERY						
1.00		0.00	0	0	0		1.00
2.00		0.00	0	0	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	3,925,235	0	0		3.00
4.00	ADULTS & PEDIATRICS	30.00	0	186,666	0		4.00
	0		3,925,235	186,666			
	M - EMERGENCY DEPARTMENT						
1.00		0.00	0	0	0		1.00
2.00	OPERATING ROOM	50.00	912,277	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00	OPERATING ROOM	50.00	0	59,723	0		4.00
	0		912,277	59,723			
	N - INCENTIVE COMPENSATION						
1.00		0.00	0	0	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
10.00		0.00	0	0	0		10.00
11.00		0.00	0	0	0		11.00
12.00		0.00	0	0	0		12.00
13.00		0.00	0	0	0		13.00
14.00		0.00	0	0	0		14.00
15.00	ADMINISTRATIVE & GENERAL	5.00	917,521	0	0		15.00
	0		917,521	0			
	O - PHYSICIAN PART A						
1.00		0.00	0	0	0		1.00
2.00		0.00	0	0	0		2.00
3.00	PHYSICIANS' PRIVATE OFFICES	192.00	143,500	0	0		3.00
	0		143,500	0			
	P - DISABILITY						
1.00		0.00	0	0	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
10.00		0.00	0	0	0		10.00
11.00		0.00	0	0	0		11.00
12.00		0.00	0	0	0		12.00
13.00		0.00	0	0	0		13.00
14.00		0.00	0	0	0		14.00
15.00		0.00	0	0	0		15.00
16.00		0.00	0	0	0		16.00
17.00		0.00	0	0	0		17.00
18.00		0.00	0	0	0		18.00
19.00		0.00	0	0	0		19.00
20.00	ADMINISTRATIVE & GENERAL	5.00	21,437	0	0		20.00
21.00	OPERATION OF PLANT	7.00	4,148	0	0		21.00
22.00	HOUSEKEEPING	9.00	9,384	0	0		22.00

RECLASSIFICATIONS | Provider CCN: 15-0149 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-6 | Date/Time Prepared: 5/30/2023 8:21 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
23.00	CAFETERIA	11.00	17,309	0	0		23.00
24.00	CENTRAL SERVICES & SUPPLY	14.00	7,066	0	0		24.00
25.00	MEDICAL RECORDS & LIBRARY	16.00	1,373	0	0		25.00
26.00	SOCIAL SERVICE	17.00	5,888	0	0		26.00
27.00	ADULTS & PEDIATRICS	30.00	163,167	0	0		27.00
28.00	INTENSIVE CARE UNIT	31.00	92,868	0	0		28.00
29.00	NURSERY	43.00	9,907	0	0		29.00
30.00	OPERATING ROOM	50.00	35,797	0	0		30.00
31.00	RECOVERY ROOM	51.00	710	0	0		31.00
32.00	RADIOLOGY-DIAGNOSTIC	54.00	33,680	0	0		32.00
33.00	RESPIRATORY THERAPY	65.00	10,039	0	0		33.00
34.00	CLINIC	90.00	21,558	0	0		34.00
35.00	EMERGENCY	91.00	2,467	0	0		35.00
36.00	PHYSICIANS' PRIVATE OFFICES	192.00	19,280	0	0		36.00
37.00	WOMEN'S RESOURCES	194.01	2,658	0	0		37.00
38.00	CENTER FOR HEALING ARTS	194.04	636	0	0		38.00
	0		459,372	0			
	Q - LAUNDRY						
1.00		0.00	0	0	0		1.00
2.00	HOUSEKEEPING	9.00	0	982,419	0		2.00
	0		0	982,419			
	R - MEDICAL SUPPLIES						
1.00		0.00	0	0	0		1.00
2.00		0.00	0	0	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	440,305	0		3.00
4.00	INTENSIVE CARE UNIT	31.00	0	188,993	0		4.00
5.00	NURSERY	43.00	0	87,259	0		5.00
6.00	OPERATING ROOM	50.00	0	3,510,039	0		6.00
7.00	RECOVERY ROOM	51.00	0	193	0		7.00
8.00	RADIOLOGY-DIAGNOSTIC	54.00	0	213,247	0		8.00
9.00	LABORATORY	60.00	0	19	0		9.00
10.00	RESPIRATORY THERAPY	65.00	0	162,440	0		10.00
11.00	CLINIC	90.00	0	8,997	0		11.00
	0		0	4,611,492			
	S - ANESTHESIA PART A						
1.00		0.00	0	0	0		1.00
2.00	OPERATING ROOM	50.00	0	4,528,902	0		2.00
	0		0	4,528,902			
	T - RADIOLOGY						
1.00		0.00	0	0	0		1.00
2.00		0.00	0	0	0		2.00
3.00	RADIOLOGY-DIAGNOSTIC	54.00	177,838	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00	0	38,136	0		6.00
	0		177,838	38,136			
	U - BLOOD BANK						
1.00		0.00	0	0	0		1.00
2.00	LABORATORY	60.00	0	38,491	0		2.00
	0		0	38,491			
500.00	Grand Total: Decreases		7,140,221	22,307,321			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0149 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-7 Part I | Date/Time Prepared: 5/30/2023 8:21 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	0	0	0	0	0	1.00
2.00	Land Improvements	0	0	0	0	0	2.00
3.00	Buildings and Fixtures	0	0	0	0	0	3.00
4.00	Building Improvements	6,375,314	164,934	0	164,934	33,164	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	21,273,126	995,182	0	995,182	1,212,956	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	27,648,440	1,160,116	0	1,160,116	1,246,120	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	27,648,440	1,160,116	0	1,160,116	1,246,120	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	0	0	1.00
2.00	Land Improvements	0	0	2.00
3.00	Buildings and Fixtures	0	0	3.00
4.00	Building Improvements	6,507,084	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	21,055,352	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	27,562,436	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	27,562,436	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0149 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-7 Part II | Date/Time Prepared: 5/30/2023 8:21 am

	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	0	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	0	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	0		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		2.00
3.00	Total (sum of lines 1-2)	0	0		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0149 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-7 Part III Date/Time Prepared: 5/30/2023 8:21 am

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: 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	6,507,085	0	6,507,085	0.236085	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	21,055,352	0	21,055,352	0.763915	0	2.00
3.00	Total (sum of lines 1-2)	27,562,437	0	27,562,437	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: 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	605,944	4,395,512	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	1,616,286	846,820	2.00
3.00	Total (sum of lines 1-2)	0	0	0	2,222,230	5,242,332	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: 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	52,271	0	151,280	0	5,205,007	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	234,569	57,962	114,931	0	2,870,568	2.00
3.00	Total (sum of lines 1-2)	286,840	57,962	266,211	0	8,075,575	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0149 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-8 | Date/Time Prepared: 5/30/2023 8:21 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	52,271	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		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)	B	-2,621	ADMINISTRATIVE & GENERAL	5.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-13,347,160			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	10,635,205			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-249,602	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines	B	-1,173	CAFETERIA	11.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	COFFEE SHOP REVENUE	B	-33,933	CAFETERIA	11.00	0	33.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0149 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-8 | Date/Time Prepared: 5/30/2023 8:21 am

	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	
34.00	CLASS REVENUE	B	-15,387	ADMINISTRATIVE & GENERAL	5.00	0	34.00
35.00	LOBBYING	B	-37,930	ADMINISTRATIVE & GENERAL	5.00	0	35.00
36.00	AHA DUES	A	-5,459	ADMINISTRATIVE & GENERAL	5.00	0	36.00
37.00	IHA DUES	A	-2,693	ADMINISTRATIVE & GENERAL	5.00	0	37.00
38.00	PHYSICIAN RECRUITMENT	A	-29,180	ADMINISTRATIVE & GENERAL	5.00	0	38.00
39.00	HENDERSON MGMT FEES	B	-254,699	ADMINISTRATIVE & GENERAL	5.00	0	39.00
40.00	HAF	A	-5,986,597	ADMINISTRATIVE & GENERAL	5.00	0	40.00
41.00	PHYSICIAN BILLING	A	-293,591	ADMINISTRATIVE & GENERAL	5.00	0	41.00
41.01	VENDING REVENUE	B	-782	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00	0	41.01
41.02	COFFEE SHOP REVENUE	B	-22,622	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00	0	41.02
41.03	CAFETERIA REVENUE	B	-166,402	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00	0	41.03
41.04	CENTER FOR HEALING ARTS REVENUE	B	-150,341	CENTER FOR HEALING ARTS	194.04	0	41.04
41.05	WOMEN'S RESOURCES REVENUE	B	13	WOMEN'S RESOURCES	194.01	0	41.05
41.06	LACTATION SERVICES REVENUE	B	-54,346	WOMEN'S RESOURCES	194.01	0	41.06
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-9,967,029				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: 15-0149 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-8-1 | Date/Time Prepared: 5/30/2023 8:21 am

	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	FACILITY RENT	4,238,476	4,238,476	1.00
2.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	VARIOUS	3,600,259	-100,066	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	VARIOUS	6,597,379	1,138,121	3.00
4.00	7.00	OPERATION OF PLANT	VARIOUS	2,875,487	1,418,710	4.00
4.01	14.00	CENTRAL SERVICES & SUPPLY	VARIOUS	344,429	0	4.01
4.02	15.00	PHARMACY	VARIOUS	2,215,805	1,353,166	4.02
4.03	16.00	MEDICAL RECORDS & LIBRARY	VARIOUS	33,736	0	4.03
4.04	30.00	ADULTS & PEDIATRICS	VARIOUS	2,245	2,245	4.04
4.05	31.00	INTENSIVE CARE UNIT	VARIOUS	12,501	12,501	4.05
4.06	54.00	RADIOLOGY-DIAGNOSTIC	VARIOUS	13,538	13,538	4.06
4.07	60.00	LABORATORY	VARIOUS	4,936	4,936	4.07
4.08	66.00	PHYSICAL THERAPY	VARIOUS	742	742	4.08
4.09	90.00	CLINIC	VARIOUS	3,370	3,370	4.09
4.10	66.00	PHYSICAL THERAPY	THERAPY SERVICES	1,512,104	2,734,063	4.10
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			21,455,007	10,819,802	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:					
6.00	B	THE WOMENS HOSP	50.00	DEACONESS HOSPI	50.00	6.00
7.00	A	DEACONESS HOSPI	51.00	PROGRESSIVE HEA	49.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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.

(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: 15-0149 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-8-1 | Date/Time Prepared: 5/30/2023 8:21 am

	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	0	10		1.00
2.00	3,700,325	0		2.00
3.00	5,459,258	0		3.00
4.00	1,456,777	0		4.00
4.01	344,429	0		4.01
4.02	862,639	0		4.02
4.03	33,736	0		4.03
4.04	0	0		4.04
4.05	0	0		4.05
4.06	0	0		4.06
4.07	0	0		4.07
4.08	0	0		4.08
4.09	0	0		4.09
4.10	-1,221,959	0		4.10
5.00	10,635,205			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	HOSPITAL		6.00
7.00	THERAPY SERVICE		7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-0149 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-8-2 | Date/Time Prepared: 5/30/2023 8:21 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	AGGREGATE-ADMINISTRATIVE & GENERAL	20,400	0	20,400	211,500	84	1.00
2.00	17.00	AGGREGATE-SOCIAL SERVICE	1,375	0	1,375	237,100	11	2.00
3.00	31.00	AGGREGATE-INTENSIVE CARE UNIT	3,662,471	3,582,471	80,000	237,100	492	3.00
4.00	50.00	AGGREGATE-OPERATING ROOM	125,000	0	125,000	246,400	480	4.00
5.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	52,038	4,038	48,000	271,900	192	5.00
6.00	60.00	AGGREGATE-LABORATORY	12,000	12,000	0	260,300	0	6.00
7.00	90.00	AGGREGATE-CLINIC	4,051,985	3,951,985	100,000	237,100	180	7.00
8.00	91.00	AGGREGATE-EMERGENCY	7,162,497	4,281,231	2,881,266	211,500	14,953	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			15,087,766	11,831,725	3,256,041		16,392	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	AGGREGATE-ADMINISTRATIVE & GENERAL	8,541	427	0	0	0	1.00
2.00	17.00	AGGREGATE-SOCIAL SERVICE	1,254	63	0	0	0	2.00
3.00	31.00	AGGREGATE-INTENSIVE CARE UNIT	56,083	2,804	0	0	50,701	3.00
4.00	50.00	AGGREGATE-OPERATING ROOM	56,861	2,843	0	0	0	4.00
5.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	25,099	1,255	0	0	0	5.00
6.00	60.00	AGGREGATE-LABORATORY	0	0	0	0	0	6.00
7.00	90.00	AGGREGATE-CLINIC	20,518	1,026	0	0	88,584	7.00
8.00	91.00	AGGREGATE-EMERGENCY	1,520,461	76,023	0	0	120,555	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,688,817	84,441	0	0	259,840	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.00	AGGREGATE-ADMINISTRATIVE & GENERAL	0	8,541	11,859	11,859		1.00
2.00	17.00	AGGREGATE-SOCIAL SERVICE	0	1,254	121	121		2.00
3.00	31.00	AGGREGATE-INTENSIVE CARE UNIT	1,107	57,190	22,810	3,605,281		3.00
4.00	50.00	AGGREGATE-OPERATING ROOM	0	56,861	68,139	68,139		4.00
5.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	0	25,099	22,901	26,939		5.00
6.00	60.00	AGGREGATE-LABORATORY	0	0	0	12,000		6.00
7.00	90.00	AGGREGATE-CLINIC	2,186	22,704	77,296	4,029,281		7.00
8.00	91.00	AGGREGATE-EMERGENCY	48,496	1,568,957	1,312,309	5,593,540		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			51,789	1,740,606	1,515,435	13,347,160		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0149 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part I | Date/Time Prepared: 5/30/2023 8:21 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	5,205,007	5,205,007				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2,870,568		2,870,568			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	15,854,704	90,013	0	15,944,717		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	19,147,641	653,336	938,714	2,018,308	22,757,999	5.00
7.00	00700	OPERATION OF PLANT	3,519,357	161,686	26,233	136,983	3,844,259	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	982,419	0	0	0	982,419	8.00
9.00	00900	HOUSEKEEPING	1,337,354	27,511	29,639	313,791	1,708,295	9.00
10.00	01000	DIETARY	368,585	49,233	7,495	72,988	498,301	10.00
11.00	01100	CAFETERIA	574,362	114,735	17,471	170,114	876,682	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	543,717	32,794	23,232	42,717	642,460	14.00
15.00	01500	PHARMACY	2,212,166	37,822	100,417	0	2,350,405	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	543,330	20,876	0	141,039	705,245	16.00
17.00	01700	SOCIAL SERVICE	501,909	4,944	0	149,390	656,243	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,219,084	1,047,663	125,784	1,799,946	9,192,477	30.00
31.00	03100	INTENSIVE CARE UNIT	6,531,117	399,270	214,785	2,669,630	9,814,802	31.00
43.00	04300	NURSERY	1,112,505	82,745	17,368	326,749	1,539,367	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,096,659	609,343	348,644	1,160,824	7,215,470	50.00
51.00	05100	RECOVERY ROOM	657,194	0	10,622	201,850	869,666	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,111,901	550,391	91,142	1,210,389	5,963,823	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,923,335	237,711	312,391	704,806	4,178,243	54.00
57.00	05700	CT SCAN	107,371	0	0	27,263	134,634	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	108,603	0	0	27,575	136,178	58.00
60.00	06000	LABORATORY	3,298,351	6,973	21,694	0	3,327,018	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	38,491	0	0	0	38,491	63.00
65.00	06500	RESPIRATORY THERAPY	1,910,203	13,185	164,663	471,424	2,559,475	65.00
66.00	06600	PHYSICAL THERAPY	1,547,628	154,164	22,109	0	1,723,901	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,749,203	0	0	0	3,749,203	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	678,641	0	0	0	678,641	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,820,314	0	0	0	2,820,314	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,004,802	316,779	257,202	1,714,801	4,293,584	90.00
91.00	09100	EMERGENCY	2,612,033	99,395	6,917	885,896	3,604,241	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	99,188,554	4,710,569	2,736,522	14,246,483	96,861,836	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	382,907	76,490	11,646	113,410	584,453	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	4,895,332	176,265	107,704	1,335,240	6,514,541	192.00
194.00	07950	OTHER DEPARTMENTS	0	0	0	0	0	194.00
194.01	07951	WOMEN'S RESOURCES	471,709	203,100	6,954	107,213	788,976	194.01
194.02	07952	MARKETING	733,034	0	787	82,747	816,568	194.02
194.03	07953	REPRODUCTIVE MEDICINE	3,123	0	0	0	3,123	194.03
194.04	07954	CENTER FOR HEALING ARTS	172,256	38,583	6,955	59,624	277,418	194.04
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	105,846,915	5,205,007	2,870,568	15,944,717	105,846,915	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0149 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part I Date/Time Prepared: 5/30/2023 8:21 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	22,757,999					5.00
7.00	00700	OPERATION OF PLANT	1,052,939	4,897,198				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	269,084	0	1,251,503			8.00
9.00	00900	HOUSEKEEPING	467,900	31,332	0	2,207,527		9.00
10.00	01000	DIETARY	136,484	56,071	0	25,438	716,294	10.00
11.00	01100	CAFETERIA	240,122	130,671	0	59,282	709,892	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	175,969	37,348	0	16,944	0	14.00
15.00	01500	PHARMACY	643,774	43,076	0	19,542	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	193,166	23,776	0	10,787	0	16.00
17.00	01700	SOCIAL SERVICE	179,744	5,631	0	2,555	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,517,810	1,193,173	112,085	541,314	0	30.00
31.00	03100	INTENSIVE CARE UNIT	2,688,292	454,725	304,085	206,298	0	31.00
43.00	04300	NURSERY	421,631	94,237	72,412	42,753	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,976,310	693,975	417,726	314,840	0	50.00
51.00	05100	RECOVERY ROOM	238,201	0	47,420	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,633,485	626,835	121,494	284,380	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,144,417	270,727	0	122,822	0	54.00
57.00	05700	CT SCAN	36,876	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	37,299	0	0	0	0	58.00
60.00	06000	LABORATORY	911,267	7,941	0	3,603	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	10,543	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	701,038	15,016	0	6,813	0	65.00
66.00	06600	PHYSICAL THERAPY	472,175	175,575	0	79,654	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,026,903	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	185,879	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	772,481	0	0	0	0	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,176,008	360,777	0	163,676	0	90.00
91.00	09100	EMERGENCY	987,198	113,200	176,281	51,356	6,402	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	20,296,995	4,334,086	1,251,503	1,952,057	716,294	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	160,081	87,114	0	39,522	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,784,326	200,747	0	91,074	0	192.00
194.00	07950	OTHER DEPARTMENTS	0	0	0	0	0	194.00
194.01	07951	WOMEN'S RESOURCES	216,100	231,309	0	104,939	0	194.01
194.02	07952	MARKETING	223,657	0	0	0	0	194.02
194.03	07953	REPRODUCTIVE MEDICINE	855	0	0	0	0	194.03
194.04	07954	CENTER FOR HEALING ARTS	75,985	43,942	0	19,935	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	22,757,999	4,897,198	1,251,503	2,207,527	716,294	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0149 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part I | Date/Time Prepared: 5/30/2023 8:21 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	2,016,649					11.00
13.00	01300	NURSING ADMINISTRATION	0	0				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	12,883	0	885,604			14.00
15.00	01500	PHARMACY	0	0	17,899	3,074,696		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	42,330	0	8	0	975,312	16.00
17.00	01700	SOCIAL SERVICE	32,207	0	2	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	369,006	0	30,819	142	56,263	30.00
31.00	03100	INTENSIVE CARE UNIT	366,705	0	46,651	191,132	120,094	31.00
43.00	04300	NURSERY	81,439	0	2,914	2,268	28,598	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	227,753	0	113,327	0	164,933	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	18,728	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	242,936	0	0	0	47,982	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	160,577	0	4,418	9,044	137,018	54.00
57.00	05700	CT SCAN	0	0	0	0	2,705	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	2,737	58.00
60.00	06000	LABORATORY	0	0	3	0	106,725	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0	1,234	63.00
65.00	06500	RESPIRATORY THERAPY	84,200	0	16,726	155,905	31,586	65.00
66.00	06600	PHYSICAL THERAPY	0	0	3,205	33	29,891	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	546,420	0	44,444	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	93,870	0	7,245	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	2,693,914	66,597	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	132,511	0	2,387	2,398	38,912	90.00
91.00	09100	EMERGENCY	67,636	0	0	0	69,620	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,820,183	0	878,649	3,054,836	975,312	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	6,902	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	128,370	0	6,292	19,145	0	192.00
194.00	07950	OTHER DEPARTMENTS	0	0	0	0	0	194.00
194.01	07951	WOMEN'S RESOURCES	31,287	0	229	0	0	194.01
194.02	07952	MARKETING	17,024	0	49	0	0	194.02
194.03	07953	REPRODUCTIVE MEDICINE	0	0	0	715	0	194.03
194.04	07954	CENTER FOR HEALING ARTS	12,883	0	385	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	2,016,649	0	885,604	3,074,696	975,312	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0149 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part I | Date/Time Prepared: 5/30/2023 8:21 am

		Cost Center Description	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			17.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
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	876,382					17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	314,603	14,327,692	0	14,327,692		30.00
31.00	03100	INTENSIVE CARE UNIT	358,966	14,551,750	0	14,551,750		31.00
43.00	04300	NURSERY	202,813	2,488,432	0	2,488,432		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	11,124,334	0	11,124,334		50.00
51.00	05100	RECOVERY ROOM	0	1,174,015	0	1,174,015		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	8,920,935	0	8,920,935		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	6,027,266	0	6,027,266		54.00
57.00	05700	CT SCAN	0	174,215	0	174,215		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	176,214	0	176,214		58.00
60.00	06000	LABORATORY	0	4,356,557	0	4,356,557		60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	50,268	0	50,268		63.00
65.00	06500	RESPIRATORY THERAPY	0	3,570,759	0	3,570,759		65.00
66.00	06600	PHYSICAL THERAPY	0	2,484,434	0	2,484,434		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	5,366,970	0	5,366,970		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	965,635	0	965,635		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	6,353,306	0	6,353,306		73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0		77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	6,170,253	0	6,170,253		90.00
91.00	09100	EMERGENCY	0	5,075,934	0	5,075,934		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0		102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	876,382	93,358,969	0	93,358,969		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	878,072	0	878,072		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	8,744,495	0	8,744,495		192.00
194.00	07950	OTHER DEPARTMENTS	0	0	0	0		194.00
194.01	07951	WOMEN'S RESOURCES	0	1,372,840	0	1,372,840		194.01
194.02	07952	MARKETING	0	1,057,298	0	1,057,298		194.02
194.03	07953	REPRODUCTIVE MEDICINE	0	4,693	0	4,693		194.03
194.04	07954	CENTER FOR HEALING ARTS	0	430,548	0	430,548		194.04
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	876,382	105,846,915	0	105,846,915		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0149 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part II | Date/Time Prepared: 5/30/2023 8:21 am

		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	90,013	0	90,013	90,013	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	653,336	938,714	1,592,050	11,395	5.00
7.00	00700	OPERATION OF PLANT	0	161,686	26,233	187,919	773	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	27,511	29,639	57,150	1,772	9.00
10.00	01000	DIETARY	0	49,233	7,495	56,728	412	10.00
11.00	01100	CAFETERIA	0	114,735	17,471	132,206	960	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	32,794	23,232	56,026	241	14.00
15.00	01500	PHARMACY	0	37,822	100,417	138,239	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	20,876	0	20,876	796	16.00
17.00	01700	SOCIAL SERVICE	0	4,944	0	4,944	843	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	1,047,663	125,784	1,173,447	10,162	30.00
31.00	03100	INTENSIVE CARE UNIT	0	399,270	214,785	614,055	15,063	31.00
43.00	04300	NURSERY	0	82,745	17,368	100,113	1,845	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	609,343	348,644	957,987	6,554	50.00
51.00	05100	RECOVERY ROOM	0	0	10,622	10,622	1,140	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	550,391	91,142	641,533	6,834	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	237,711	312,391	550,102	3,979	54.00
57.00	05700	CT SCAN	0	0	0	0	154	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	156	58.00
60.00	06000	LABORATORY	0	6,973	21,694	28,667	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	13,185	164,663	177,848	2,662	65.00
66.00	06600	PHYSICAL THERAPY	0	154,164	22,109	176,273	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	316,779	257,202	573,981	9,682	90.00
91.00	09100	EMERGENCY	0	99,395	6,917	106,312	5,002	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	4,710,569	2,736,522	7,447,091	80,425	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	76,490	11,646	88,136	640	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	176,265	107,704	283,969	7,539	192.00
194.00	07950	OTHER DEPARTMENTS	0	0	0	0	0	194.00
194.01	07951	WOMEN'S RESOURCES	0	203,100	6,954	210,054	605	194.01
194.02	07952	MARKETING	0	0	787	787	467	194.02
194.03	07953	REPRODUCTIVE MEDICINE	0	0	0	0	0	194.03
194.04	07954	CENTER FOR HEALING ARTS	0	38,583	6,955	45,538	337	194.04
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	5,205,007	2,870,568	8,075,575	90,013	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0149 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part II | Date/Time Prepared: 5/30/2023 8:21 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,603,445					5.00
7.00	00700	OPERATION OF PLANT	74,187	262,879				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	18,959	0	18,959			8.00
9.00	00900	HOUSEKEEPING	32,967	1,682	0	93,571		9.00
10.00	01000	DIETARY	9,616	3,010	0	1,078	70,844	10.00
11.00	01100	CAFETERIA	16,918	7,014	0	2,513	70,211	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	12,398	2,005	0	718	0	14.00
15.00	01500	PHARMACY	45,358	2,312	0	828	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	13,610	1,276	0	457	0	16.00
17.00	01700	SOCIAL SERVICE	12,664	302	0	108	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	177,396	64,050	1,699	22,947	0	30.00
31.00	03100	INTENSIVE CARE UNIT	189,399	24,409	4,609	8,744	0	31.00
43.00	04300	NURSERY	29,707	5,059	1,098	1,812	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	139,244	37,252	6,321	13,345	0	50.00
51.00	05100	RECOVERY ROOM	16,783	0	719	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	115,090	33,648	1,841	12,054	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	80,632	14,532	0	5,206	0	54.00
57.00	05700	CT SCAN	2,598	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	2,628	0	0	0	0	58.00
60.00	06000	LABORATORY	64,205	426	0	153	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	743	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	49,393	806	0	289	0	65.00
66.00	06600	PHYSICAL THERAPY	33,268	9,425	0	3,376	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	72,352	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	13,096	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	54,426	0	0	0	0	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	82,858	19,366	0	6,938	0	90.00
91.00	09100	EMERGENCY	69,555	6,077	2,672	2,177	633	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,430,050	232,651	18,959	82,743	70,844	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	11,279	4,676	0	1,675	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	125,718	10,776	0	3,860	0	192.00
194.00	07950	OTHER DEPARTMENTS	0	0	0	0	0	194.00
194.01	07951	WOMEN'S RESOURCES	15,226	12,417	0	4,448	0	194.01
194.02	07952	MARKETING	15,758	0	0	0	0	194.02
194.03	07953	REPRODUCTIVE MEDICINE	60	0	0	0	0	194.03
194.04	07954	CENTER FOR HEALING ARTS	5,354	2,359	0	845	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,603,445	262,879	18,959	93,571	70,844	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0149 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part II | Date/Time Prepared: 5/30/2023 8:21 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	229,822					11.00
13.00	01300	NURSING ADMINISTRATION	0	0				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,468	0	72,856			14.00
15.00	01500	PHARMACY	0	0	1,472	188,209		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,824	0	1	0	41,840	16.00
17.00	01700	SOCIAL SERVICE	3,670	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	42,052	0	2,535	9	2,417	30.00
31.00	03100	INTENSIVE CARE UNIT	41,791	0	3,838	11,700	5,159	31.00
43.00	04300	NURSERY	9,281	0	240	139	1,228	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	25,955	0	9,323	0	7,028	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	804	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	27,686	0	0	0	2,061	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	18,300	0	363	554	5,886	54.00
57.00	05700	CT SCAN	0	0	0	0	116	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	118	58.00
60.00	06000	LABORATORY	0	0	0	0	4,585	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0	53	63.00
65.00	06500	RESPIRATORY THERAPY	9,596	0	1,376	9,543	1,357	65.00
66.00	06600	PHYSICAL THERAPY	0	0	264	2	1,284	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	44,953	0	1,909	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	7,722	0	311	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	164,899	2,861	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	15,101	0	196	147	1,672	90.00
91.00	09100	EMERGENCY	7,708	0	0	0	2,991	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	207,432	0	72,283	186,993	41,840	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	787	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	14,629	0	518	1,172	0	192.00
194.00	07950	OTHER DEPARTMENTS	0	0	0	0	0	194.00
194.01	07951	WOMEN'S RESOURCES	3,566	0	19	0	0	194.01
194.02	07952	MARKETING	1,940	0	4	0	0	194.02
194.03	07953	REPRODUCTIVE MEDICINE	0	0	0	44	0	194.03
194.04	07954	CENTER FOR HEALING ARTS	1,468	0	32	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	229,822	0	72,856	188,209	41,840	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0149 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part II | Date/Time Prepared: 5/30/2023 8:21 am

		Cost Center Description	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			17.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
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	22,531					17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,088	1,504,802	0	1,504,802		30.00
31.00	03100	INTENSIVE CARE UNIT	9,229	927,996	0	927,996		31.00
43.00	04300	NURSERY	5,214	155,736	0	155,736		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,203,009	0	1,203,009		50.00
51.00	05100	RECOVERY ROOM	0	30,068	0	30,068		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	840,747	0	840,747		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	679,554	0	679,554		54.00
57.00	05700	CT SCAN	0	2,868	0	2,868		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	2,902	0	2,902		58.00
60.00	06000	LABORATORY	0	98,036	0	98,036		60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	796	0	796		63.00
65.00	06500	RESPIRATORY THERAPY	0	252,870	0	252,870		65.00
66.00	06600	PHYSICAL THERAPY	0	223,892	0	223,892		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	119,214	0	119,214		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	21,129	0	21,129		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	222,186	0	222,186		73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0		77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	709,941	0	709,941		90.00
91.00	09100	EMERGENCY	0	203,127	0	203,127		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0		102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	22,531	7,198,873	0	7,198,873		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	107,193	0	107,193		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	448,181	0	448,181		192.00
194.00	07950	OTHER DEPARTMENTS	0	0	0	0		194.00
194.01	07951	WOMEN'S RESOURCES	0	246,335	0	246,335		194.01
194.02	07952	MARKETING	0	18,956	0	18,956		194.02
194.03	07953	REPRODUCTIVE MEDICINE	0	104	0	104		194.03
194.04	07954	CENTER FOR HEALING ARTS	0	55,933	0	55,933		194.04
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	22,531	8,075,575	0	8,075,575		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0149 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B-1 | Date/Time Prepared: 5/30/2023 8:21 am

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	123,167					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2,463,108				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,130	0	51,707,907			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	15,460	805,469	6,545,276	-22,757,999	83,088,916	5.00
7.00	00700	OPERATION OF PLANT	3,826	22,509	444,228	0	3,844,259	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	982,419	8.00
9.00	00900	HOUSEKEEPING	651	25,432	1,017,608	0	1,708,295	9.00
10.00	01000	DIETARY	1,165	6,431	236,696	0	498,301	10.00
11.00	01100	CAFETERIA	2,715	14,991	551,673	0	876,682	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	776	19,934	138,529	0	642,460	14.00
15.00	01500	PHARMACY	895	86,163	0	0	2,350,405	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	494	0	457,382	0	705,245	16.00
17.00	01700	SOCIAL SERVICE	117	0	484,466	0	656,243	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	24,791	107,930	5,837,139	0	9,192,477	30.00
31.00	03100	INTENSIVE CARE UNIT	9,448	184,298	8,657,433	0	9,814,802	31.00
43.00	04300	NURSERY	1,958	14,903	1,059,631	0	1,539,367	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	14,419	299,156	3,764,496	0	7,215,470	50.00
51.00	05100	RECOVERY ROOM	0	9,114	654,591	0	869,666	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	13,024	78,205	3,925,235	0	5,963,823	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,625	268,049	2,285,651	0	4,178,243	54.00
57.00	05700	CT SCAN	0	0	88,412	0	134,634	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	89,426	0	136,178	58.00
60.00	06000	LABORATORY	165	18,615	0	0	3,327,018	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0	38,491	63.00
65.00	06500	RESPIRATORY THERAPY	312	141,290	1,528,807	0	2,559,475	65.00
66.00	06600	PHYSICAL THERAPY	3,648	18,971	0	0	1,723,901	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	3,749,203	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	678,641	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	2,820,314	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	7,496	220,694	5,561,019	0	4,293,584	90.00
91.00	09100	EMERGENCY	2,352	5,935	2,872,920	0	3,604,241	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	111,467	2,348,089	46,200,618	-22,757,999	74,103,837	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,810	9,993	367,782	0	584,453	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	4,171	92,416	4,330,120	0	6,514,541	192.00
194.00	07950	OTHER DEPARTMENTS	0	0	0	0	0	194.00
194.01	07951	WOMEN'S RESOURCES	4,806	5,967	347,687	0	788,976	194.01
194.02	07952	MARKETING	0	675	268,343	0	816,568	194.02
194.03	07953	REPRODUCTIVE MEDICINE	0	0	0	0	3,123	194.03
194.04	07954	CENTER FOR HEALING ARTS	913	5,968	193,357	0	277,418	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	5,205,007	2,870,568	15,944,717		22,757,999	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	42.259753	1.165425	0.308361		0.273899	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			90,013		1,603,445	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.001741		0.019298	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: 15-0149 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B-1 | Date/Time Prepared: 5/30/2023 8:21 am

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (GROSS REVENUE)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTES)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	101,751					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	107,772,428				8.00
9.00	00900	HOUSEKEEPING	651	0	101,100			9.00
10.00	01000	DIETARY	1,165	0	1,165	25,845		10.00
11.00	01100	CAFETERIA	2,715	0	2,715	25,614	4,383	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	776	0	776	0	28	14.00
15.00	01500	PHARMACY	895	0	895	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	494	0	494	0	92	16.00
17.00	01700	SOCIAL SERVICE	117	0	117	0	70	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	24,791	9,652,500	24,791	0	802	30.00
31.00	03100	INTENSIVE CARE UNIT	9,448	26,187,102	9,448	0	797	31.00
43.00	04300	NURSERY	1,958	6,235,989	1,958	0	177	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	14,419	35,969,325	14,419	0	495	50.00
51.00	05100	RECOVERY ROOM	0	4,083,740	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	13,024	10,462,804	13,024	0	528	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,625	0	5,625	0	349	54.00
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
60.00	06000	LABORATORY	165	0	165	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	312	0	312	0	183	65.00
66.00	06600	PHYSICAL THERAPY	3,648	0	3,648	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	7,496	0	7,496	0	288	90.00
91.00	09100	EMERGENCY	2,352	15,180,968	2,352	231	147	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	90,051	107,772,428	89,400	25,845	3,956	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,810	0	1,810	0	15	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	4,171	0	4,171	0	279	192.00
194.00	07950	OTHER DEPARTMENTS	0	0	0	0	0	194.00
194.01	07951	WOMEN'S RESOURCES	4,806	0	4,806	0	68	194.01
194.02	07952	MARKETING	0	0	0	0	37	194.02
194.03	07953	REPRODUCTIVE MEDICINE	0	0	0	0	0	194.03
194.04	07954	CENTER FOR HEALING ARTS	913	0	913	0	28	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	4,897,198	1,251,503	2,207,527	716,294	2,016,649	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	48.129237	0.011612	21.835084	27.714993	460.107004	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	262,879	18,959	93,571	70,844	229,822	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	2.583552	0.000176	0.925529	2.741110	52.434862	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: 15-0149 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B-1 | Date/Time Prepared: 5/30/2023 8:21 am

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TOTAL PATIENT DAYS)	
			13.00	14.00	15.00	16.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	0					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	6,402,545				14.00
15.00	01500	PHARMACY	0	129,404	3,052,625			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	58	0	212,676,876		16.00
17.00	01700	SOCIAL SERVICE	0	14	0	0	22,915	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	222,811	141	12,268,484	8,226	30.00
31.00	03100	INTENSIVE CARE UNIT	0	337,269	189,760	26,187,102	9,386	31.00
43.00	04300	NURSERY	0	21,066	2,252	6,235,989	5,303	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	819,301	0	35,969,326	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	4,083,740	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	10,462,804	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	31,942	8,979	29,877,499	0	54.00
57.00	05700	CT SCAN	0	0	0	589,947	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	596,715	0	58.00
60.00	06000	LABORATORY	0	22	0	23,272,003	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	269,078	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	120,921	154,786	6,887,399	0	65.00
66.00	06600	PHYSICAL THERAPY	0	23,171	33	6,517,856	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,950,389	0	9,691,295	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	678,641	0	1,579,787	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	2,674,575	14,521,832	0	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	17,258	2,381	8,485,052	0	90.00
91.00	09100	EMERGENCY	0	0	0	15,180,968	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	6,352,267	3,032,907	212,676,876	22,915	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	45,488	19,008	0	0	192.00
194.00	07950	OTHER DEPARTMENTS	0	0	0	0	0	194.00
194.01	07951	WOMEN'S RESOURCES	0	1,654	0	0	0	194.01
194.02	07952	MARKETING	0	355	0	0	0	194.02
194.03	07953	REPRODUCTIVE MEDICINE	0	0	710	0	0	194.03
194.04	07954	CENTER FOR HEALING ARTS	0	2,781	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	0	885,604	3,074,696	975,312	876,382	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	0.138321	1.007230	0.004586	38.244905	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	72,856	188,209	41,840	22,531	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	0.011379	0.061655	0.000197	0.983242	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: 15-0149 | Period: From 01/01/2022 To 12/31/2022 | Worksheet C Part I Date/Time Prepared: 5/30/2023 8:21 am

Title XVIII | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	14,327,692		14,327,692	0	14,327,692	30.00
31.00	03100	INTENSIVE CARE UNIT	14,551,750		14,551,750	22,810	14,574,560	31.00
43.00	04300	NURSERY	2,488,432		2,488,432	0	2,488,432	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	11,124,334		11,124,334	68,139	11,192,473	50.00
51.00	05100	RECOVERY ROOM	1,174,015		1,174,015	0	1,174,015	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	8,920,935		8,920,935	0	8,920,935	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,027,266		6,027,266	22,901	6,050,167	54.00
57.00	05700	CT SCAN	174,215		174,215	0	174,215	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	176,214		176,214	0	176,214	58.00
60.00	06000	LABORATORY	4,356,557		4,356,557	0	4,356,557	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	50,268		50,268	0	50,268	63.00
65.00	06500	RESPIRATORY THERAPY	3,570,759	0	3,570,759	0	3,570,759	65.00
66.00	06600	PHYSICAL THERAPY	2,484,434	0	2,484,434	0	2,484,434	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,366,970		5,366,970	0	5,366,970	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	965,635		965,635	0	965,635	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,353,306		6,353,306	0	6,353,306	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0		0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	6,170,253		6,170,253	77,296	6,247,549	90.00
91.00	09100	EMERGENCY	5,075,934		5,075,934	1,312,309	6,388,243	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,713,614		2,713,614		2,713,614	92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0		0		0	102.00
200.00		Subtotal (see instructions)	96,072,583	0	96,072,583	1,503,455	97,576,038	200.00
201.00		Less Observation Beds	2,713,614		2,713,614		2,713,614	201.00
202.00		Total (see instructions)	93,358,969	0	93,358,969	1,503,455	94,862,424	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0149 | Period: From 01/01/2022 To 12/31/2022 | Worksheet C Part I Date/Time Prepared: 5/30/2023 8:21 am

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		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,652,500		9,652,500			30.00
31.00	03100	INTENSIVE CARE UNIT	26,187,102		26,187,102			31.00
43.00	04300	NURSERY	6,235,989		6,235,989			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	11,544,743	24,424,583	35,969,326	0.309273	0.000000	50.00
51.00	05100	RECOVERY ROOM	283,279	3,800,461	4,083,740	0.287485	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	10,462,804	0	10,462,804	0.852633	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,265,965	26,611,534	29,877,499	0.201733	0.000000	54.00
57.00	05700	CT SCAN	126,401	463,546	589,947	0.295306	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	249,861	346,854	596,715	0.295307	0.000000	58.00
60.00	06000	LABORATORY	11,717,809	11,554,194	23,272,003	0.187202	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	230,634	38,444	269,078	0.186816	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	6,877,801	9,598	6,887,399	0.518448	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	501,053	6,016,803	6,517,856	0.381174	0.000000	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,066,712	7,624,583	9,691,295	0.553793	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	75,361	1,504,426	1,579,787	0.611244	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,227,975	5,293,857	14,521,832	0.437500	0.000000	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0.000000	0.000000	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	299,441	8,185,611	8,485,052	0.727191	0.000000	90.00
91.00	09100	EMERGENCY	3,247,836	11,933,132	15,180,968	0.334362	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,377,151	1,238,833	2,615,984	1.037321	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0			102.00
200.00		Subtotal (see instructions)	103,630,417	109,046,459	212,676,876			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	103,630,417	109,046,459	212,676,876			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0149 | Period: From 01/01/2022 To 12/31/2022 | Worksheet C Part I Date/Time Prepared: 5/30/2023 8:21 am

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		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.311167		50.00
51.00	05100	RECOVERY ROOM	0.287485		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.852633		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.202499		54.00
57.00	05700	CT SCAN	0.295306		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.295307		58.00
60.00	06000	LABORATORY	0.187202		60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0.186816		63.00
65.00	06500	RESPIRATORY THERAPY	0.518448		65.00
66.00	06600	PHYSICAL THERAPY	0.381174		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.553793		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.611244		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.437500		73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000		77.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.736301		90.00
91.00	09100	EMERGENCY	0.420806		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.037321		92.00
		OTHER REIMBURSABLE COST CENTERS			
102.00	10200	OPIOID TREATMENT PROGRAM			102.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0149 | Period: From 01/01/2022 To 12/31/2022 | Worksheet C Part I Date/Time Prepared: 5/30/2023 8:21 am

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	14,327,692		14,327,692	0	14,327,692	30.00
31.00	03100	INTENSIVE CARE UNIT	14,551,750		14,551,750	22,810	14,574,560	31.00
43.00	04300	NURSERY	2,488,432		2,488,432	0	2,488,432	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	11,124,334		11,124,334	68,139	11,192,473	50.00
51.00	05100	RECOVERY ROOM	1,174,015		1,174,015	0	1,174,015	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	8,920,935		8,920,935	0	8,920,935	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,027,266		6,027,266	22,901	6,050,167	54.00
57.00	05700	CT SCAN	174,215		174,215	0	174,215	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	176,214		176,214	0	176,214	58.00
60.00	06000	LABORATORY	4,356,557		4,356,557	0	4,356,557	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	50,268		50,268	0	50,268	63.00
65.00	06500	RESPIRATORY THERAPY	3,570,759	0	3,570,759	0	3,570,759	65.00
66.00	06600	PHYSICAL THERAPY	2,484,434	0	2,484,434	0	2,484,434	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,366,970		5,366,970	0	5,366,970	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	965,635		965,635	0	965,635	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,353,306		6,353,306	0	6,353,306	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0		0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	6,170,253		6,170,253	77,296	6,247,549	90.00
91.00	09100	EMERGENCY	5,075,934		5,075,934	1,312,309	6,388,243	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,713,614		2,713,614		2,713,614	92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0		0		0	102.00
200.00		Subtotal (see instructions)	96,072,583	0	96,072,583	1,503,455	97,576,038	200.00
201.00		Less Observation Beds	2,713,614		2,713,614		2,713,614	201.00
202.00		Total (see instructions)	93,358,969	0	93,358,969	1,503,455	94,862,424	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0149 | Period: From 01/01/2022 To 12/31/2022 | Worksheet C Part I Date/Time Prepared: 5/30/2023 8:21 am

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	9,652,500		9,652,500			30.00
31.00	03100	INTENSIVE CARE UNIT	26,187,102		26,187,102			31.00
43.00	04300	NURSERY	6,235,989		6,235,989			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	11,544,743	24,424,583	35,969,326	0.309273	0.000000	50.00
51.00	05100	RECOVERY ROOM	283,279	3,800,461	4,083,740	0.287485	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	10,462,804	0	10,462,804	0.852633	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,265,965	26,611,534	29,877,499	0.201733	0.000000	54.00
57.00	05700	CT SCAN	126,401	463,546	589,947	0.295306	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	249,861	346,854	596,715	0.295307	0.000000	58.00
60.00	06000	LABORATORY	11,717,809	11,554,194	23,272,003	0.187202	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	230,634	38,444	269,078	0.186816	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	6,877,801	9,598	6,887,399	0.518448	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	501,053	6,016,803	6,517,856	0.381174	0.000000	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,066,712	7,624,583	9,691,295	0.553793	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	75,361	1,504,426	1,579,787	0.611244	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,227,975	5,293,857	14,521,832	0.437500	0.000000	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0.000000	0.000000	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	299,441	8,185,611	8,485,052	0.727191	0.000000	90.00
91.00	09100	EMERGENCY	3,247,836	11,933,132	15,180,968	0.334362	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,377,151	1,238,833	2,615,984	1.037321	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0			102.00
200.00		Subtotal (see instructions)	103,630,417	109,046,459	212,676,876			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	103,630,417	109,046,459	212,676,876			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0149 | Period: From 01/01/2022 To 12/31/2022 | Worksheet C Part I Date/Time Prepared: 5/30/2023 8:21 am

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		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.311167		50.00
51.00	05100	RECOVERY ROOM	0.287485		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.852633		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.202499		54.00
57.00	05700	CT SCAN	0.295306		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.295307		58.00
60.00	06000	LABORATORY	0.187202		60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0.186816		63.00
65.00	06500	RESPIRATORY THERAPY	0.518448		65.00
66.00	06600	PHYSICAL THERAPY	0.381174		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.553793		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.611244		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.437500		73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000		77.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.736301		90.00
91.00	09100	EMERGENCY	0.420806		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.037321		92.00
		OTHER REIMBURSABLE COST CENTERS			
102.00	10200	OPIOID TREATMENT PROGRAM			102.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

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

Provider CCN: 15-0149 | Period: From 01/01/2022 To 12/31/2022 | Worksheet C Part II Date/Time Prepared: 5/30/2023 8:21 am

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	11,124,334	1,203,009	9,921,325	0	0	50.00
51.00	05100	RECOVERY ROOM	1,174,015	30,068	1,143,947	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	8,920,935	840,747	8,080,188	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,027,266	679,554	5,347,712	0	0	54.00
57.00	05700	CT SCAN	174,215	2,868	171,347	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	176,214	2,902	173,312	0	0	58.00
60.00	06000	LABORATORY	4,356,557	98,036	4,258,521	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	50,268	796	49,472	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	3,570,759	252,870	3,317,889	0	0	65.00
66.00	06600	PHYSICAL THERAPY	2,484,434	223,892	2,260,542	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,366,970	119,214	5,247,756	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	965,635	21,129	944,506	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,353,306	222,186	6,131,120	0	0	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	6,170,253	709,941	5,460,312	0	0	90.00
91.00	09100	EMERGENCY	5,075,934	203,127	4,872,807	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,713,614	285,005	2,428,609	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
200.00		Subtotal (sum of lines 50 thru 199)	64,704,709	4,895,344	59,809,365	0	0	200.00
201.00		Less Observation Beds	2,713,614	285,005	2,428,609	0	0	201.00
202.00		Total (line 200 minus line 201)	61,991,095	4,610,339	57,380,756	0	0	202.00

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

Provider CCN: 15-0149 | Period: From 01/01/2022 To 12/31/2022 | Worksheet C Part II Date/Time Prepared: 5/30/2023 8:21 am

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	11,124,334	35,969,326	0.309273		50.00
51.00	05100	RECOVERY ROOM	1,174,015	4,083,740	0.287485		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	8,920,935	10,462,804	0.852633		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,027,266	29,877,499	0.201733		54.00
57.00	05700	CT SCAN	174,215	589,947	0.295306		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	176,214	596,715	0.295307		58.00
60.00	06000	LABORATORY	4,356,557	23,272,003	0.187202		60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	50,268	269,078	0.186816		63.00
65.00	06500	RESPIRATORY THERAPY	3,570,759	6,887,399	0.518448		65.00
66.00	06600	PHYSICAL THERAPY	2,484,434	6,517,856	0.381174		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,366,970	9,691,295	0.553793		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	965,635	1,579,787	0.611244		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,353,306	14,521,832	0.437500		73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0.000000		77.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	6,170,253	8,485,052	0.727191		90.00
91.00	09100	EMERGENCY	5,075,934	15,180,968	0.334362		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,713,614	2,615,984	1.037321		92.00
		OTHER REIMBURSABLE COST CENTERS					
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0.000000		102.00
200.00		Subtotal (sum of lines 50 thru 199)	64,704,709	170,601,285			200.00
201.00		Less Observation Beds	2,713,614	0			201.00
202.00		Total (line 200 minus line 201)	61,991,095	170,601,285			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-0149 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part I Date/Time Prepared: 5/30/2023 8:21 am

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	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,504,802	0	1,504,802	10,148	148.29	30.00
31.00	INTENSIVE CARE UNIT	927,996		927,996	9,386	98.87	31.00
43.00	NURSERY	155,736		155,736	5,303	29.37	43.00
200.00	Total (lines 30 through 199)	2,588,534		2,588,534	24,837		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	126	18,685				30.00
31.00	INTENSIVE CARE UNIT	0	0				31.00
43.00	NURSERY	0	0				43.00
200.00	Total (lines 30 through 199)	126	18,685				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-0149 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part II Date/Time Prepared: 5/30/2023 8:21 am

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,203,009	35,969,326	0.033445	759,140	25,389	50.00
51.00	05100	RECOVERY ROOM	30,068	4,083,740	0.007363	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	840,747	10,462,804	0.080356	20,097	1,615	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	679,554	29,877,499	0.022745	12,175	277	54.00
57.00	05700	CT SCAN	2,868	589,947	0.004861	6,217	30	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	2,902	596,715	0.004863	3,484	17	58.00
60.00	06000	LABORATORY	98,036	23,272,003	0.004213	381,974	1,609	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	796	269,078	0.002958	19,521	58	63.00
65.00	06500	RESPIRATORY THERAPY	252,870	6,887,399	0.036715	5,426	199	65.00
66.00	06600	PHYSICAL THERAPY	223,892	6,517,856	0.034351	4,350	149	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	119,214	9,691,295	0.012301	179,004	2,202	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	21,129	1,579,787	0.013375	3,021	40	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	222,186	14,521,832	0.015300	152,817	2,338	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0.000000	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	709,941	8,485,052	0.083670	4,879	408	90.00
91.00	09100	EMERGENCY	203,127	15,180,968	0.013380	14,871	199	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	285,005	2,615,984	0.108948	12,414	1,352	92.00
200.00		Total (lines 50 through 199)	4,895,344	170,601,285		1,579,390	35,882	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0149 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part III Date/Time Prepared: 5/30/2023 8:21 am

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

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	10,148	0.00	126	30.00
31.00	03100	INTENSIVE CARE UNIT		0	9,386	0.00	0	31.00
43.00	04300	NURSERY		0	5,303	0.00	0	43.00
200.00		Total (lines 30 through 199)		0	24,837		126	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
43.00	04300	NURSERY	0	43.00
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0149 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part IV Date/Time Prepared: 5/30/2023 8:21 am

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		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
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
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
60.00	06000	LABORATORY	0	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		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: 15-0149 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part IV Date/Time Prepared: 5/30/2023 8:21 am

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		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	35,969,326	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	4,083,740	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	10,462,804	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	29,877,499	0.000000	54.00
57.00	05700	CT SCAN	0	0	0	589,947	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	596,715	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	23,272,003	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	269,078	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	6,887,399	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	6,517,856	0.000000	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	9,691,295	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,579,787	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	14,521,832	0.000000	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0.000000	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	8,485,052	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	15,180,968	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	2,615,984	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	170,601,285		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0149 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part IV Date/Time Prepared: 5/30/2023 8:21 am

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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	759,140	0	3,284,445	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	445	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	20,097	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	12,175	0	1,275,387	0	54.00
57.00	05700	CT SCAN	0.000000	6,217	0	6,153	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	3,484	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	381,974	0	638,322	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0.000000	19,521	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.000000	5,426	0	242	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	4,350	0	49,794	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	179,004	0	794,261	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	3,021	0	211,790	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	152,817	0	309,287	0	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	4,879	0	51,682	0	90.00
91.00	09100	EMERGENCY	0.000000	14,871	0	47,205	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	12,414	0	5,673	0	92.00
200.00		Total (lines 50 through 199)		1,579,390	0	6,674,686	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0149 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part V Date/Time Prepared: 5/30/2023 8:21 am

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		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.309273	3,284,445	0	0	1,015,790	50.00
51.00	05100	RECOVERY ROOM	0.287485	445	0	0	128	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.852633	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.201733	1,275,387	0	0	257,288	54.00
57.00	05700	CT SCAN	0.295306	6,153	0	0	1,817	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.295307	0	0	0	0	58.00
60.00	06000	LABORATORY	0.187202	638,322	0	0	119,495	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0.186816	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.518448	242	0	0	125	65.00
66.00	06600	PHYSICAL THERAPY	0.381174	49,794	0	0	18,980	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.553793	794,261	0	0	439,856	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.611244	211,790	0	0	129,455	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.437500	309,287	0	0	135,313	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.727191	51,682	0	0	37,583	90.00
91.00	09100	EMERGENCY	0.334362	47,205	0	0	15,784	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.037321	5,673	0	0	5,885	92.00
200.00		Subtotal (see instructions)		6,674,686	0	0	2,177,499	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		6,674,686	0	0	2,177,499	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0149 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part V Date/Time Prepared: 5/30/2023 8:21 am

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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	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
60.00	06000	LABORATORY	0	0		60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0		63.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0		77.00
		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)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	0		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-0149 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part I Date/Time Prepared: 5/30/2023 8:21 am

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	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,504,802	0	1,504,802	10,148	148.29	30.00
31.00	INTENSIVE CARE UNIT	927,996		927,996	9,386	98.87	31.00
43.00	NURSERY	155,736		155,736	5,303	29.37	43.00
200.00	Total (lines 30 through 199)	2,588,534		2,588,534	24,837		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	550	81,560	30.00
31.00	INTENSIVE CARE UNIT	1,761	174,110	31.00
43.00	NURSERY	462	13,569	43.00
200.00	Total (lines 30 through 199)	2,773	269,239	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-0149 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part II Date/Time Prepared: 5/30/2023 8:21 am

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		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,203,009	35,969,326	0.033445	372,096	12,445	50.00
51.00	05100	RECOVERY ROOM	30,068	4,083,740	0.007363	56,285	414	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	840,747	10,462,804	0.080356	382,696	30,752	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	679,554	29,877,499	0.022745	244,184	5,554	54.00
57.00	05700	CT SCAN	2,868	589,947	0.004861	12,301	60	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	2,902	596,715	0.004863	7,528	37	58.00
60.00	06000	LABORATORY	98,036	23,272,003	0.004213	898,471	3,785	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	796	269,078	0.002958	81,130	240	63.00
65.00	06500	RESPIRATORY THERAPY	252,870	6,887,399	0.036715	937,362	34,415	65.00
66.00	06600	PHYSICAL THERAPY	223,892	6,517,856	0.034351	57,341	1,970	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	119,214	9,691,295	0.012301	74,506	916	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	21,129	1,579,787	0.013375	17,257	231	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	222,186	14,521,832	0.015300	511,645	7,828	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0.000000	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	709,941	8,485,052	0.083670	319	27	90.00
91.00	09100	EMERGENCY	203,127	15,180,968	0.013380	47,489	635	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	285,005	2,615,984	0.108948	63,618	6,931	92.00
200.00		Total (lines 50 through 199)	4,895,344	170,601,285		3,764,228	106,240	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0149 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part III Date/Time Prepared: 5/30/2023 8:21 am

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

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	10,148	0.00	550	30.00
31.00	03100	INTENSIVE CARE UNIT		0	9,386	0.00	1,761	31.00
43.00	04300	NURSERY		0	5,303	0.00	462	43.00
200.00		Total (lines 30 through 199)		0	24,837		2,773	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
43.00	04300	NURSERY	0	43.00
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0149 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part IV Date/Time Prepared: 5/30/2023 8:21 am

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		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
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
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
60.00	06000	LABORATORY	0	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
		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: 15-0149 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part IV Date/Time Prepared: 5/30/2023 8:21 am

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	35,969,326	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	4,083,740	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	10,462,804	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	29,877,499	0.000000	54.00
57.00	05700	CT SCAN	0	0	0	589,947	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	596,715	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	23,272,003	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	269,078	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	6,887,399	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	6,517,856	0.000000	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	9,691,295	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,579,787	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	14,521,832	0.000000	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0.000000	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	8,485,052	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	15,180,968	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	2,615,984	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	170,601,285		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0149 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part IV Date/Time Prepared: 5/30/2023 8:21 am

Title XIX | 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	372,096	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	56,285	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	382,696	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	244,184	0	0	0	54.00
57.00	05700	CT SCAN	0.000000	12,301	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	7,528	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	898,471	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0.000000	81,130	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.000000	937,362	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	57,341	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	74,506	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	17,257	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	511,645	0	0	0	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	319	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	47,489	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	63,618	0	0	0	92.00
200.00		Total (lines 50 through 199)		3,764,228	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0149 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part V Date/Time Prepared: 5/30/2023 8:21 am

Title XIX | 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	0.309273	0	0	301,027	0	50.00
51.00	05100	RECOVERY ROOM	0.287485	0	0	27,757	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.852633	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.201733	0	0	323,197	0	54.00
57.00	05700	CT SCAN	0.295306	0	0	3,142	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.295307	0	0	14,932	0	58.00
60.00	06000	LABORATORY	0.187202	0	0	333,745	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0.186816	0	0	2,312	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.518448	0	0	58	0	65.00
66.00	06600	PHYSICAL THERAPY	0.381174	0	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.553793	0	0	43,390	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.611244	0	0	5,356	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.437500	0	0	29,465	0	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.727191	0	0	9,832	0	90.00
91.00	09100	EMERGENCY	0.334362	0	0	228,053	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.037321	0	0	38,071	0	92.00
200.00		Subtotal (see instructions)		0	0	1,360,337	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	1,360,337	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0149 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part V Date/Time Prepared: 5/30/2023 8:21 am

Title XIX | 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	93,100		50.00
51.00	05100	RECOVERY ROOM	0	7,980		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	65,200		54.00
57.00	05700	CT SCAN	0	928		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	4,410		58.00
60.00	06000	LABORATORY	0	62,478		60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	432		63.00
65.00	06500	RESPIRATORY THERAPY	0	30		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	24,029		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	3,274		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	12,891		73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0		77.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	7,150		90.00
91.00	09100	EMERGENCY	0	76,252		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	39,492		92.00
200.00		Subtotal (see instructions)	0	397,646		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	397,646		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0149 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-1 | Date/Time Prepared: 5/30/2023 8:21 am

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)	10,148	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	10,148	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)	8,226	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	126	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)	14,327,692	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)	14,327,692	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)	14,327,692	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,411.87	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	177,896	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)	177,896	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0149 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-1 | Date/Time Prepared: 5/30/2023 8:21 am

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	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	14,574,560	9,386	1,552.80	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	528,870	48.00
48.01	Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)	0	48.01
49.00	Total Program inpatient costs (sum of lines 41 through 48.01)(see instructions)	706,766	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)	18,685	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	35,882	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	54,567	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	652,199	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
55.01	Permanent adjustment amount per discharge	0.00	55.01
55.02	Adjustment amount per discharge (contractor use only)	0.00	55.02
56.00	Target amount (line 54 x sum of lines 55, 55.01, and 55.02)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)	0.00	59.00
60.00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)	0.00	60.00
61.00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	1,922	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,411.87	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	2,713,614	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0149 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-1 | Date/Time Prepared: 5/30/2023 8:21 am

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	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	1,504,802	14,327,692	0.105028	2,713,614	285,005	90.00
91.00	Nursing Program cost	0	14,327,692	0.000000	2,713,614	0	91.00
92.00	Allied health cost	0	14,327,692	0.000000	2,713,614	0	92.00
93.00	All other Medical Education	0	14,327,692	0.000000	2,713,614	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0149 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-1 | Date/Time Prepared: 5/30/2023 8:21 am

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)	10,148	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	10,148	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)	8,226	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	550	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)	5,303	15.00
16.00	Nursery days (title V or XIX only)	462	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)	14,327,692	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)	14,327,692	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)	14,327,692	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,411.87	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	776,529	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)	776,529	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0149 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-1 | Date/Time Prepared: 5/30/2023 8:21 am

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)	2,488,432	5,303	469.25	462	216,794	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	14,574,560	9,386	1,552.80	1,761	2,734,481	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)	1,566,614	48.00
48.01	Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)	0	48.01
49.00	Total Program inpatient costs (sum of lines 41 through 48.01)(see instructions)	5,294,418	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)	269,239	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	106,240	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	375,479	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	4,918,939	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
55.01	Permanent adjustment amount per discharge	0.00	55.01
55.02	Adjustment amount per discharge (contractor use only)	0.00	55.02
56.00	Target amount (line 54 x sum of lines 55, 55.01, and 55.02)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)	0.00	59.00
60.00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)	0.00	60.00
61.00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	1,922	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,411.87	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	2,713,614	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0149 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-1 | Date/Time Prepared: 5/30/2023 8:21 am

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	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	1,504,802	14,327,692	0.105028	2,713,614	285,005	90.00
91.00	Nursing Program cost	0	14,327,692	0.000000	2,713,614	0	91.00
92.00	Allied health cost	0	14,327,692	0.000000	2,713,614	0	92.00
93.00	All other Medical Education	0	14,327,692	0.000000	2,713,614	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0149 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-3 | Date/Time Prepared: 5/30/2023 8:21 am

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		139,698		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.311167	759,140	236,219	50.00
51.00	05100	RECOVERY ROOM	0.287485	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.852633	20,097	17,135	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.202499	12,175	2,465	54.00
57.00	05700	CT SCAN	0.295306	6,217	1,836	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.295307	3,484	1,029	58.00
60.00	06000	LABORATORY	0.187202	381,974	71,506	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0.186816	19,521	3,647	63.00
65.00	06500	RESPIRATORY THERAPY	0.518448	5,426	2,813	65.00
66.00	06600	PHYSICAL THERAPY	0.381174	4,350	1,658	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.553793	179,004	99,131	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.611244	3,021	1,847	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.437500	152,817	66,857	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.736301	4,879	3,592	90.00
91.00	09100	EMERGENCY	0.420806	14,871	6,258	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.037321	12,414	12,877	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,579,390	528,870	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		1,579,390		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0149 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-3 | Date/Time Prepared: 5/30/2023 8:21 am

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		390,690		30.00
31.00	03100	INTENSIVE CARE UNIT		2,011,181		31.00
43.00	04300	NURSERY		235,520		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.311167	372,096	115,784	50.00
51.00	05100	RECOVERY ROOM	0.287485	56,285	16,181	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.852633	382,696	326,299	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.202499	244,184	49,447	54.00
57.00	05700	CT SCAN	0.295306	12,301	3,633	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.295307	7,528	2,223	58.00
60.00	06000	LABORATORY	0.187202	898,471	168,196	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0.186816	81,130	15,156	63.00
65.00	06500	RESPIRATORY THERAPY	0.518448	937,362	485,973	65.00
66.00	06600	PHYSICAL THERAPY	0.381174	57,341	21,857	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.553793	74,506	41,261	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.611244	17,257	10,548	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.437500	511,645	223,845	73.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	77.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.736301	319	235	90.00
91.00	09100	EMERGENCY	0.420806	47,489	19,984	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.037321	63,618	65,992	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		3,764,228	1,566,614	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		3,764,228		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0149	Period: From 01/01/2022 To 12/31/2022	Worksheet E Part A Date/Time Prepared: 5/30/2023 8:21 am
	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)	328,955	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	114,527	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)	0	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)	0	2.04
3.00	Managed Care Simulated Payments	160,702	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	68.73	4.00
	Indirect Medical Education Adjustment		
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)	0.00	5.00
5.01	FTE cap adjustment for qualifing hospitals under §131 of the CAA 2021 (see instructions)	0.00	5.01
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)	0.00	6.00
6.26	Rural track program FTE cap limitation adjustment after the cap-building window closed under §127 of the CAA 2021 (see instructions)	0.00	6.26
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.	0.00	7.01
7.02	Adjustment (increase or decrease) to the hospital's rural track program FTE limitation(s) for rural track programs with a rural track for Medicare GME affiliated programs in accordance with 413.75(b) and 87 FR 49075 (August 10, 2022) (see instructions)	0.00	7.02
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.	0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)	0.00	8.02
8.21	The amount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (see instructions)	0.00	8.21
9.00	Sum of lines 5 and 5.01, plus line 6, plus lines 6.26 through 6.49, minus lines 7 and 7.01, plus or minus line 7.02, plus/minus line 8, plus lines 8.01 through 8.27 (see instructions)	0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.	0.00	11.00
12.00	Current year allowable FTE (see instructions)	0.00	12.00
13.00	Total allowable FTE count for the prior year.	0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.	0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.	0.00	15.00
16.00	Adjustment for residents in initial years of the program (see instructions)	0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure	0.00	17.00
18.00	Adjusted rolling average FTE count	0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)	0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.000000	21.00
22.00	IME payment adjustment (see instructions)	0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)	0	22.01
	Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA		
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).	0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)	0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)	0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)	0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)	0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)	0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)	0	28.01
29.00	Total IME payment (sum of lines 22 and 28)	0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	0	29.01
	Disproportionate Share Adjustment		
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	6.54	30.00
31.00	Percentage of Medicaid patient days (see instructions)	50.50	31.00
32.00	Sum of lines 30 and 31	57.04	32.00
33.00	Allowable disproportionate share percentage (see instructions)	12.00	33.00
34.00	Disproportionate share adjustment (see instructions)	13,305	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0149	Period: From 01/01/2022 To 12/31/2022	Worksheet E Part A Date/Time Prepared: 5/30/2023 8:21 am
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		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	Uncompensated Care Payment Adjustment			
35.00	Total uncompensated care amount (see instructions)	0	0	35.00
35.01	Factor 3 (see instructions)	0.000000000	0.000000000	35.01
35.02	Hospital UCP, including supplemental UCP (If line 34 is zero, enter zero on this line) (see instructions)	322,745	323,995	35.02
35.03	Pro rata share of the hospital UCP, including supplemental UCP (see instructions)	241,396	81,665	35.03
36.00	Total UCP adjustment (sum of columns 1 and 2 on line 35.03)	323,061		36.00
	Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)			
40.00	Total Medicare discharges (see instructions)	0		40.00
41.00	Total ESRD Medicare discharges (see instructions)	0		41.00
41.01	Total ESRD Medicare covered and paid discharges (see instructions)	0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days (see instructions)	0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00
47.00	Subtotal (see instructions)	779,848		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)	779,848	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	34,664	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)	0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).	0	52.00
53.00	Nursing and Allied Health Managed Care payment	0	53.00
54.00	Special add-on payments for new technologies	0	54.00
54.01	Islet isolation add-on payment	0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)	0	55.00
55.01	Cellular therapy acquisition cost (see instructions)	0	55.01
56.00	Cost of physicians' services in a teaching hospital (see intructions)	0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).	0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)	0	58.00
59.00	Total (sum of amounts on lines 49 through 58)	814,512	59.00
60.00	Primary payer payments	0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	814,512	61.00
62.00	Deductibles billed to program beneficiaries	68,392	62.00
63.00	Coinsurance billed to program beneficiaries	0	63.00
64.00	Allowable bad debts (see instructions)	21,627	64.00
65.00	Adjusted reimbursable bad debts (see instructions)	14,058	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	20,071	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	760,178	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)	0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)	0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	70.00
70.50	Rural Community Hospital Demonstration Project (§410A Demonstration) adjustment (see instructions)	0	70.50
70.75	N95 respirator payment adjustment amount (see instructions)	0	70.75
70.87	Demonstration payment adjustment amount before sequestration	0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)	0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)	0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)	0	70.91
70.92	Bundled Model 1 discount amount (see instructions)	0	70.92
70.93	HVBP payment adjustment amount (see instructions)	0	70.93
70.94	HRR adjustment amount (see instructions)	0	70.94
70.95	Recovery of accelerated depreciation	0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0149	Period: From 01/01/2022 To 12/31/2022	Worksheet E Part A Date/Time Prepared: 5/30/2023 8:21 am
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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)		760,178	71.00
71.01	Sequestration adjustment (see instructions)		9,578	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
71.03	Sequestration adjustment-PARHM or CHART pass-throughs			71.03
72.00	Interim payments		790,363	72.00
72.01	Interim payments-PARHM or CHART			72.01
73.00	Tentative settlement (for contractor use only)		0	73.00
73.01	Tentative settlement-PARHM or CHART (for contractor use only)			73.01
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		-39,763	74.00
74.01	Balance due provider/program-PARHM or CHART (see instructions)			74.01
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		470,000	75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00

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

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 15-0149 | Period: From 01/01/2022 To 12/31/2022 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 5/30/2023 8:21 am

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		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	328,955	0	328,955		328,955	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	114,527	0		114,527	114,527	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00						2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	0	0	0		0	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	0	0		0	0	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	160,702	0	160,702	0	160,702	4.00
	Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0	9.01
	Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1200	0.1200	0.1200	0.1200		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	13,305	0	9,869	3,436	13,305	11.00
11.01	Uncompensated care payments	36.00	323,061	0	241,396	81,665	323,061	11.01
	Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	779,848	0	580,220	199,628	779,848	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	779,848	0	580,220	199,628	779,848	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	34,664	0	25,768	8,896	34,664	16.00

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 15-0149 | Period: From 01/01/2022 To 12/31/2022 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 5/30/2023 8:21 am

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		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	0	17.00
17.01	Net organ aquisition cost							17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			0	605,988	208,524	814,512	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	34,664	0	25,768	8,896	34,664	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	0	0	0	0	0	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	34,664	0	25,768	8,896	34,664	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.000000	0.000000		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			0		0	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				0	0	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 15-0149 | Period: From 01/01/2022 To 12/31/2022 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/30/2023 8:21 am

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		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	328,955	328,955		328,955	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	114,527		114,527	114,527	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00					2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	0	0		0	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	0		0	0	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	160,702	0	0	0	4.00
	Indirect Medical Education Adjustment						
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA						
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
	Disproportionate Share Adjustment						
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1200	0.1200	0.1200		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	13,305	9,869	3,436	13,305	11.00
11.01	Uncompensated care payments	36.00	323,061	241,396	81,665	323,061	11.01
	Additional payment for high percentage of ESRD beneficiary discharges						
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	779,848	580,220	199,628	779,848	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	779,848	580,220	199,628	779,848	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	34,664	25,768	8,896	34,664	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			605,988	208,524	814,512	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 15-0149 | Period: From 01/01/2022 To 12/31/2022 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/30/2023 8:21 am

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		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	34,664	25,768	8,896	34,664	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	0	0	0	0	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	34,664	25,768	8,896	34,664	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	0	0		0	28.00
29.00	Low volume adjustment on or after October 1	70.97	0		0	0	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	0	0	0	0	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	0	0	0	0	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	0	0	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0149	Period: From 01/01/2022 To 12/31/2022	Worksheet E Part B Date/Time Prepared: 5/30/2023 8:21 am
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		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	2,177,499	2.00
3.00	OPPS payments	1,789,220	3.00
4.00	Outlier payment (see instructions)	9,133	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	0	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	0	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	1,798,353	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	309,404	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	1,488,949	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	1,488,949	30.00
31.00	Primary payer payments	84	31.00
32.00	Subtotal (line 30 minus line 31)	1,488,865	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)	17,967	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	11,679	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	12,598	36.00
37.00	Subtotal (see instructions)	1,500,544	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	PS&R OTHER ADJUSTMENTS	16	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.75	N95 respirator payment adjustment amount (see instructions)	0	39.75
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	1,500,560	40.00
40.01	Sequestration adjustment (see instructions)	18,907	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
40.03	Sequestration adjustment-PARHM or CHART pass-throughs		40.03
41.00	Interim payments	1,470,410	41.00
41.01	Interim payments-PARHM or CHART		41.01
42.00	Tentative settlement (for contractors use only)	0	42.00
42.01	Tentative settlement-PARHM or CHART (for contractor use only)		42.01
43.00	Balance due provider/program (see instructions)	11,243	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	10,000	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0149	Period: From 01/01/2022 To 12/31/2022	Worksheet E Part B Date/Time Prepared: 5/30/2023 8:21 am
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		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: 15-0149 | Period: From 01/01/2022 To 12/31/2022 | Worksheet E-1 Part I Date/Time Prepared: 5/30/2023 8:21 am

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		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		790,363		1,470,410	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)		790,363		1,470,410	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		0		11,243	6.01
6.02	SETTLEMENT TO PROGRAM		39,763		0	6.02
7.00	Total Medicare program liability (see instructions)		750,600		1,481,653	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: 15-0149	Period: From 01/01/2022 To 12/31/2022	Worksheet E-1 Part II Date/Time Prepared: 5/30/2023 8:21 am
	Title XVIII	Hospital	PPS

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

OUTLIER RECONCILIATION AT TENTATIVE SETTLEMENT	Provider CCN: 15-0149	Period: From 01/01/2022 To 12/31/2022	Worksheet E-5 Date/Time Prepared: 5/30/2023 8:21 am
	Title XVIII		PPS

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

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 15-0149 | Period: From 01/01/2022 To 12/31/2022 | Worksheet G | Date/Time Prepared: 5/30/2023 8:21 am

		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	0	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	35,268,264	0	0	0	4.00
5.00	Other receivable	1,034,142	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-17,962,727	0	0	0	6.00
7.00	Inventory	824,182	0	0	0	7.00
8.00	Prepaid expenses	965,448	0	0	0	8.00
9.00	Other current assets	116,336	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)	20,245,645	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	0	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	6,523,075	0	0	0	17.00
18.00	Accumulated depreciation	-4,124,102	0	0	0	18.00
19.00	Fixed equipment	659,478	0	0	0	19.00
20.00	Accumulated depreciation	-659,478	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	0	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	20,395,875	0	0	0	25.00
26.00	Accumulated depreciation	-17,308,531	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	5,486,317	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	34,971,085	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	34,971,085	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	60,703,047	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	6,237,552	0	0	0	37.00
38.00	Salaries, wages, and fees payable	6,416,799	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	9,273,368	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	1,080,286	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	23,008,005	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	32,216,540	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	32,216,540	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	55,224,545	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	5,478,502				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)	5,478,502	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	60,703,047	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-0149 | Period: From 01/01/2022 To 12/31/2022 | Worksheet G-1 | Date/Time Prepared: 5/30/2023 8:21 am

		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		12,357,417		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		14,094,372				2.00
3.00	Total (sum of line 1 and line 2)		26,451,789		0		3.00
4.00	ROUNDING	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)		26,451,789		0		11.00
12.00	DISTRIBUTION TO MEMBERS	20,973,287		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)		20,973,287		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		5,478,502		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	ROUNDING		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	DISTRIBUTION TO MEMBERS		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: 15-0149 | Period: From 01/01/2022 To 12/31/2022 | Worksheet G-2 Parts I & II Date/Time Prepared: 5/30/2023 8:21 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	15,888,489		15,888,489	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	15,888,489		15,888,489	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	34,259,414		34,259,414	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)	34,259,414		34,259,414	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	50,147,903		50,147,903	17.00
18.00	Ancillary services	56,630,398	96,422,949	153,053,347	18.00
19.00	Outpatient services	4,924,428	31,593,834	36,518,262	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	NON-REIMBURSABLE	0	5,324,935	5,324,935	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	111,702,729	133,341,718	245,044,447	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		115,813,944		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)		115,813,944		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 15-0149	Period: From 01/01/2022 To 12/31/2022	Worksheet G-3 Date/Time Prepared: 5/30/2023 8:21 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	245,044,447	1.00
2.00	Less contractual allowances and discounts on patients' accounts	116,698,213	2.00
3.00	Net patient revenues (line 1 minus line 2)	128,346,234	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	115,813,944	4.00
5.00	Net income from service to patients (line 3 minus line 4)	12,532,290	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	-52,271	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	474,515	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	272,795	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	185,907	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER INCOME	681,136	24.00
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	1,562,082	25.00
26.00	Total (line 5 plus line 25)	14,094,372	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)	14,094,372	29.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 15-0149	Period: From 01/01/2022 To 12/31/2022	Worksheet L Parts I-III Date/Time Prepared: 5/30/2023 8:21 am
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	34,664	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	0	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)	49.32	3.00
4.00	Number of interns & residents (see instructions)	0.00	4.00
5.00	Indirect medical education percentage (see instructions)	0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)	0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	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)	34,664	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