

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

FORM APPROVED

OMB NO. 0938-0050

EXPIRES 03-31-2022

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 15-0075	Period: From 10/01/2021 To 09/30/2022	Worksheet S Parts I-III Date/Time Prepared: 2/28/2023 8:13 pm
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PART I - COST REPORT STATUS

Provider Electronically prepared cost report
use only Manually prepared cost report
3. If this is an amended report enter the number of times the provider resubmitted this cost report
4. Medicare Utilization. Enter "F" for full or "L" for low.

Date: 2/28/2023 Time: 8:13 pm

Contractor use only	5. <input type="checkbox"/> 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. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.
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PART II - CERTIFICATION BY A CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OR PROVIDER(S)

MI SREPRESENTATION 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 BLUFFTON REGIONAL MEDICAL CENTER (15-0075) for the cost reporting period beginning 10/01/2021 and ending 09/30/2022 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR	CHECKBOX	ELECTRONIC SIGNATURE STATEMENT	
1			I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name			2
3	Signatory Title	VICE PRESIDENT		3
4	Date			4

Cost Center Description	Title V	Title XVIII		HIT	Title XIX	
		Part A	Part B			
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	91,035	21,671	0	0	1.00
2.00 Subprovider - IPF	0	0	0	0	0	2.00
3.00 Subprovider - IRF	0	0	0	0	0	3.00
5.00 Swing Bed - SNF	0	0	0	0	0	5.00
6.00 Swing Bed - NF	0	0	0	0	0	6.00
7.00 SKILLED NURSING FACILITY	0	0	0	0	0	7.00
200.00 Total	0	91,035	21,671	0	0	200.00

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

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete and review the information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 15-0075

Period:

From 10/01/2021

To 09/30/2022

Worksheet S-2

Part I

Date/Time Prepared:

2/28/2023 8:13 pm

	1.00	2.00	3.00	4.00						
Hospital and Hospital Health Care Complex Address:										
1.00	Street: 303 S. MAIN STREET	PO Box:								
2.00	City: BLUFFTON	State: IN	Zip Code: 46714-	County: WELLS						
		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	BLUFFTON REGIONAL MEDICAL CENTER	150075	99915	1	07/01/1966	N	P	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	BLUFFTON REGIONAL MEDICAL CENTER	15U075	23060		01/15/2020	N	P	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00
							From:	To:		
							1.00	2.00		
20.00	Cost Reporting Period (mm/dd/yyyy)						10/01/2021	09/30/2022	20.00	
21.00	Type of Control (see instructions)						4			21.00
							1.00	2.00	3.00	
Inpatient PPS Information										
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section 412.106(c)(2) (Pickle amendment hospital)? In column 2, enter "Y" for yes or "N" for no.		Y		N					22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)		N		N					22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.		N		N					22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.		N		N		N			22.03
22.04	Did this hospital receive a geographic reclassification from urban to rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.		N		N		N			22.04
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.		3		N					23.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 15-0075		Period: From 10/01/2021 To 09/30/2022	Worksheet S-2 Part I Date/Time Prepared: 2/28/2023 8:13 pm	
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid days	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.	49	21	2	1	800	41	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
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 classification 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
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
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)				Y		Y	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
45.00	Prospective Payment System (PPS)-Capital				V	XVIII	XIX	
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section 412.320? (see instructions)				1.00	2.00	3.00	
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	45.00
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	46.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.				N	N	N	47.00
	Teaching Hospitals							48.00
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2.				N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.				N			57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.				N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.				N			59.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA			Provider CCN: 15-0075	Period: From 10/01/2021 To 09/30/2022	Worksheet S-2 Part I Date/Time Prepared: 2/28/2023 8:13 pm	
			NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
			1.00	2.00	3.00	
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.	N			60.00	
			Y/N	IME	Direct GME	
			1.00	2.00	3.00	4.00
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 baseline FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)					61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).					61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)					61.05
61.06	Enter the amount of ACA \$5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)					61.06
			Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count
			1.00	2.00	3.00	4.00
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0.00	0.00	61.20
					1.00	
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)						
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)				0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)				0.00	62.01
Teaching Hospitals that Claim Residents in Nonprovider Settings						
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)			N		63.00
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
			1.00	2.00	3.00	
Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.						
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	64.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 15-0075	Period: From 10/01/2021 To 09/30/2022	Worksheet S-2 Part I Date/Time Prepared: 2/28/2023 8:13 pm	
Line Number	Text Description	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
66.00	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
				1.00	2.00	3.00	
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
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)			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
				1.00	2.00	3.00	
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.			0.00	0.00	0.000000	67.00
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)						
75.00	Inpatient Rehabilitation Facility PPS			1.00	2.00	3.00	
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			70.00
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)						71.00
76.00				N			75.00
							76.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0075	Period: From 10/01/2021 To 09/30/2022	Worksheet S-2 Part I Date/Time Prepared: 2/28/2023 8:13 pm	
				1.00	
Long Term Care Hospital PPS 80.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no. N 80.00 81.00 Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no. N 81.00 TEFRA Providers 85.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no. N 85.00 86.00 Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no. N 86.00 87.00 Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no. N 87.00					
		V	XIX		
		1.00	2.00		
Title V and XIX Services 90.00 Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column. N Y 90.00 91.00 Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column. N N 91.00 92.00 Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column. N N 92.00 93.00 Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column. N N 93.00 94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column. N N 94.00 95.00 If line 94 is "Y", enter the reduction percentage in the applicable column. 0.00 0.00 95.00 96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column. N N 96.00 97.00 If line 96 is "Y", enter the reduction percentage in the applicable column. 0.00 0.00 97.00 98.00 Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 0.00 N Y 98.00 98.01 Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. N Y 98.01 98.02 Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. N Y 98.02 98.03 Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. N N 98.03 98.04 Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. N N 98.04 98.05 Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. N Y 98.05 98.06 Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. N Y 98.06 Rural Providers 105.00 Does this hospital qualify as a CAH? N 105.00 106.00 If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions) 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
				N	109.00
					1.00
				N	110.00
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.					

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0075	Period: From 10/01/2021 To 09/30/2022	Worksheet S-2 Part I Date/Time Prepared: 2/28/2023 8:13 pm
			1.00	2.00
111.00 If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.			N	111.00
			1.00	2.00
112.00 Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.			N	112.00
Miscellaneous Cost Reporting Information				
115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospital providers) based on the definition in CMS Pub. 15-1, chapter 22, §2208.1.			N	0115.00
116.00 Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.			Y	116.00
117.00 Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.			N	117.00
118.00 Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.			1	118.00
		Premiums	Losses	Insurance
		1.00	2.00	3.00
118.01 List amounts of malpractice premiums and paid losses:		229,848	674	0118.01
			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				
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	119.00
121.00 Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.			Y	121.00
122.00 Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.			N	122.00
Transplant Center Information				
125.00 Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.			N	125.00
126.00 If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				126.00
127.00 If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				127.00
128.00 If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				128.00
129.00 If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				129.00
130.00 If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				130.00
131.00 If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				131.00
132.00 If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				132.00
133.00 Removed and reserved				133.00
134.00 If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.				134.00
All Providers				
140.00 Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)			Y	HB1848
				140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA			Provider CCN: 15-0075	Period: From 10/01/2021 To 09/30/2022	Worksheet S-2 Part I Date/Time Prepared: 2/28/2023 8:13 pm
	1.00	2.00	3.00		
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.					
141.00	Name: CHS / COMMUNITY HEALTH SYSTEMS, INC.	Contractor's Name: WPS	Contractor's Number: 10301		
142.00	Street: 4000 MERIDIAN BLVD	PO Box:	142.00		
143.00	City: FRANKLIN	State: TN	Zip Code: 37067	143.00	
1.00					
144.00	Are provider based physicians' costs included in Worksheet A?			Y	144.00
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.			1.00	2.00
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
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
			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
156.00	Subprovider - IPF	N	N	N	N
157.00	Subprovider - IRF	N	N	N	N
158.00	SUBPROVIDER				
159.00	SNF	N	N	N	N
160.00	HOME HEALTH AGENCY	N	N	N	N
161.00	CMHC		N	N	N
165.00	Multi campus			1.00	
Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.			N		165.00
			Name	County	State
			0	1.00	2.00
				3.00	4.00
				FTE/Campus	
				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
1.00					
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			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	0171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-0075	Period: From 10/01/2021 To 09/30/2022	Worksheet S-2 Part II Date/Time Prepared: 2/28/2023 8:13 pm	
			Y/N 1.00	Date 2.00	
<p>General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.</p> <p>COMPLETED BY ALL HOSPITALS</p> <p>Provider Organization and Operation</p>					
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 1.00	Date 2.00	V/I 3.00		
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.		N	2.00	
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)		N	3.00	
	Y/N 1.00	Type 2.00	Date 3.00		
<p>Financial Data and Reports</p>					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.		N	4.00	
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.		N	5.00	
	Y/N 1.00	Legal Oper. 2.00			
<p>Approved Educational Activities</p>					
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				
<p>Bad Debts</p>					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.		Y	12.00	
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.		N	13.00	
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.		N	14.00	
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.		Y	15.00	
	Part A		Part B		
	Y/N 1.00	Date 2.00	Y/N 3.00	Date 4.00	
<p>PS&R Data</p>					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)		Y 01/19/2023	Y 01/19/2023	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		N	N	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		N	N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		N	N	19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 15-0075

Period:

From 10/01/2021

To 09/30/2022

Worksheet S-2

Part II

Date/Time Prepared:

2/28/2023 8:13 pm

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

COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)

Capital Related Cost		
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions.	
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.	
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions.	
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.	
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.	
Interest Expense		
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.	
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.	
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	
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.	
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.	
Provider-Based Physicians		
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.	
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.	
	Y/N	Date
	1.00	2.00

Home Office Costs		
36.00	Were home office costs claimed on the cost report?	
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	
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.	
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	
	Y	
	Y	
	Y	12/31/2021
	N	
	N	
		36.00
		37.00
		38.00
		39.00
		40.00

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.
42.00	Enter the employer/company name of the cost report preparer.
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.
	KUZI WA
	CHS
	615-465-3416
	TSI GA
	KUZI WA_TSI GA@CHS.NET
	41.00
	42.00
	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 15-0075

Period:

Worksheet S-2

From 10/01/2021

Part II

To 09/30/2022

Date/Time Prepared:

2/28/2023 8:13 pm

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 15-0075

Period:

From 10/01/2021

To 09/30/2022

Worksheet S-3

Part I

Date/Time Prepared:

2/28/2023 8:13 pm

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	Title V				
					1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)		30.00	45	16,425	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)			45	16,425	0.00		0	7.00		
8.00 INTENSIVE CARE UNIT		31.00	9	3,285	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							13.00	
14.00 Total (see instructions)			54	19,710	0.00		0	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		44.00	0	0			0	19.00		
20.00 NURSING FACILITY									20.00	
21.00 OTHER LONG TERM CARE									21.00	
22.00 HOME HEALTH AGENCY									22.00	
23.00 AMBULATORY SURGICAL CENTER (D. P.)									23.00	
24.00 HOSPICE									24.00	
24.10 HOSPICE (non-distinct part)		30.00							24.10	
25.00 CMHC - CMHC									25.00	
26.00 RURAL HEALTH CLINIC									26.00	
26.25 FEDERALLY QUALIFIED HEALTH CENTER		89.00							26.25	
27.00 Total (sum of lines 14-26)			54						27.00	
28.00 Observation Bed Days									28.00	
29.00 Ambulance Trips									29.00	
30.00 Employee discount days (see instructions)									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)			0	0					32.01	
33.00 LTCH non-covered days									33.00	
33.01 LTCH site neutral days and discharges									33.01	

Component	I/P Days / O/P Visits / Trips			Full Time	Equivalents	
	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)	843	36	3,187			1.00
2.00 HMO and other (see instructions)	1,005	593				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	888	0	1,457			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)	1,731	36	4,644			7.00
8.00 INTENSIVE CARE UNIT	32	1	96			8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	1,763	280	5,167	0.00	142.45	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	0	0	0	0.00		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)			5			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	0	0	0.00	142.45	27.00
28.00 Observation Bed Days		0	578			28.00
29.00 Ambulance Trips	0					29.00
30.00 Employee discount days (see instructions)			44			30.00
31.00 Employee discount days - IRF	0		0			31.00
32.00 Labor & delivery days (see instructions)	0	41	68			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)	0		0			32.01
33.00 LTCH non-covered days	0					33.00
33.01 LTCH site neutral days and discharges	0	0				33.01

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00	15.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)			0	256	222	1,059 1.00
2.00 HMO and other (see instructions)				271	0	2.00
3.00 HMO IPF Subprovider					0	3.00
4.00 HMO IRF Subprovider					0	4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	256	222	1,059	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	0.00					19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D. P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instructions)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days				0		33.00
33.01 LTCH site neutral days and discharges				0		33.01

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0075

Worksheet S-3

Part II

Date/Time Prepared:
2/28/2023 8:13 pm

	Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)								
							1.00	2.00						
PART II - WAGE DATA														
SALARIES														
1.00	Total salaries (see instructions)	200.00	12,474,142	0	12,474,142	361,848.00	34.47	1.00						
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00						
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00						
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00						
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01						
5.00	Physician and Non Physician-Part B		0	0	0	0.00	0.00	5.00						
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00	6.00						
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00						
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01						
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00	8.00						
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00						
10.00	Excluded area salaries (see instructions)		107	-107	0	0.00	0.00	10.00						
OTHER WAGES & RELATED COSTS														
11.00	Contract labor: Direct Patient Care		2,581,994	0	2,581,994	20,349.00	126.89	11.00						
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00						
13.00	Contract labor: Physician-Part A - Administrative		103,570	0	103,570	839.35	123.39	13.00						
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00	14.00						
14.01	Home office salaries		1,265,859	0	1,265,859	31,246.00	40.51	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)		3,431,014	0	3,431,014			17.00						
18.00	Wage-related costs (other) (see instructions)							18.00						
19.00	Excluded areas		0	0	0			19.00						
20.00	Non-physician anesthetist Part A		0	0	0			20.00						
21.00	Non-physician anesthetist Part B		0	0	0			21.00						
22.00	Physician Part A - Administrative		0	0	0			22.00						
22.01	Physician Part A - Teaching		0	0	0			22.01						
23.00	Physician Part B		0	0	0			23.00						
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00						
25.00	Interns & residents (in an approved program)		0	0	0			25.00						
25.50	Home office wage-related (core)	299,182	0	299,182				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: 15-0075

Worksheet S-3

Part II

Date/Time Prepared:
2/28/2023 8:13 pm

	Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
1. 00	2. 00	3. 00	4. 00	5. 00	6. 00		
25.53	Home office: Physicians Part A - Teaching - wage-related (core)		0	0	0		25.53
OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	76,253	0	76,253	1,763.00	43.25
27.00	Administrative & General	5.00	1,613,480	-288,412	1,325,068	52,378.00	25.30
28.00	Administrative & General under contract (see inst.)		57,091	0	57,091	368.53	154.92
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	29.00
30.00	Operation of Plant	7.00	294,217	0	294,217	10,286.00	28.60
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	31.00
32.00	Housekeeping	9.00	325,374	0	325,374	18,960.00	17.16
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	33.00
34.00	Dietary	10.00	954	-761	193	5.26	36.69
35.00	Dietary under contract (see instructions)		792,170	0	792,170	50,073.96	15.82
36.00	Cafeteria	11.00	0	761	761	20.74	36.69
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	37.00
38.00	Nursing Administration	13.00	579,037	288,412	867,449	20,498.00	42.32
39.00	Central Services and Supply	14.00	163,588	0	163,588	7,313.00	22.37
40.00	Pharmacy	15.00	582,668	0	582,668	11,587.00	50.29
41.00	Medical Records & Medical Records Library	16.00	185,734	0	185,734	7,003.00	26.52
42.00	Social Service	17.00	183,872	0	183,872	0.00	0.00
43.00	Other General Service	18.00	0	0	0	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0075

Worksheet S-3

Part III

Date/Time Prepared:
2/28/2023 8:13 pm

	Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		13,323,403	0	13,323,403	412,290.49	32.32 1.00
2.00	Excluded area salaries (see instructions)		107	-107	0	0.00	0.00 2.00
3.00	Subtotal salaries (line 1 minus line 2)		13,323,296	107	13,323,403	412,290.49	32.32 3.00
4.00	Subtotal other wages & related costs (see inst.)		3,951,423	0	3,951,423	52,434.35	75.36 4.00
5.00	Subtotal wage-related costs (see inst.)		3,730,196	0	3,730,196	0.00	28.00 5.00
6.00	Total (sum of lines 3 thru 5)		21,004,915	107	21,005,022	464,724.84	45.20 6.00
7.00	Total overhead cost (see instructions)		4,854,438	0	4,854,438	180,256.49	26.93 7.00

HOSPITAL WAGE RELATED COSTS

Provider CCN: 15-0075

Period:
From 10/01/2021
To 09/30/2022Worksheet S-3
Part IV
Date/Time Prepared:
2/28/2023 8:13 pm

		Amount Reported	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	306,465	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)			
5.00	401K/TSA Plan Administration Fees	0	5.00
6.00	Legal /Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
HEALTH AND INSURANCE COST			
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	1,967,282	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	4,974	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	-5,413	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	-150	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	9,470	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	Workers' Compensation Insurance	229,340	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
TAXES			
17.00	FICA-Employers Portion Only	721,956	17.00
18.00	Medicare Taxes - Employers Portion Only	168,844	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	28,247	20.00
OTHER			
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	0	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	3,431,015	24.00
Part B - Other than Core Related Cost			
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 15-0075

Period:

From 10/01/2021

Worksheet S-3

Part V

To 09/30/2022

Date/Time Prepared:

2/28/2023 8:13 pm

Cost Center Description		Contract Labor	Benefit Cost	
		1.00	2.00	
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	2,581,994	3,431,015	1.00
2.00	Hospital	2,581,994	3,431,015	2.00
3.00	SUBPROVIDER - IPF			3.00
4.00	SUBPROVIDER - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	SKILLED NURSING FACILITY	0	0	8.00
9.00	NURSING FACILITY			9.00
10.00	OTHER LONG TERM CARE I			10.00
11.00	Hospital-Based HHA			11.00
12.00	AMBULATORY SURGICAL CENTER (D. P.) I			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	RENAL DIALYSIS I			17.00
18.00	Other	0	0	18.00

			1.00		
<u>Uncompensated and indigent care cost computation</u>					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.168917		1.00	
<u>Medicaid (see instructions for each line)</u>					
2.00	Net revenue from Medicaid	7,537,760	2.00		
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00		
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	Y	4.00		
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0	5.00		
6.00	Medicaid charges	43,550,856	6.00		
7.00	Medicaid cost (line 1 times line 6)	7,356,480	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)	0	8.00		
<u>Children's Health Insurance Program (CHIP) (see instructions for each line)</u>					
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		
<u>Other state or local government indigent care program (see instructions for each line)</u>					
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		
<u>Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)</u>					
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)	0	19.00		
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
<u>Uncompensated Care (see instructions for each line)</u>					
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	1,693,989	0	1,693,989	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	286,144	0	286,144	21.00
22.00	Payments received from patients for amounts previously written off as charity care	3,999	0	3,999	22.00
23.00	Cost of charity care (line 21 minus line 22)	282,145	0	282,145	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)		2,291,072	26.00	
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		32,168	27.00	
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		49,489	27.01	
28.00	Non-Medicare bad debt expense (see instructions)		2,241,583	28.00	
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		395,962	29.00	
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		678,107	30.00	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		678,107	31.00	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES				Provider CCN: 15-0075	Period: From 10/01/2021 To 09/30/2022	Worksheet A
Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)
		1.00	2.00	3.00	4.00	5.00
GENERAL SERVICE COST CENTERS						
1. 00	00100 CAP REL COSTS-BLDG & FIXT		1,083,250	1,083,250	754,166	1,837,416
2. 00	00200 CAP REL COSTS-MVBL EQUIP		3,338,687	3,338,687	134,745	3,473,432
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	76,253	64,707	140,960	2,588,158	2,729,118
5. 01	01160 COMMUNICATIONS	0	0	0	399,041	399,041
5. 02	00540 ADMITTING	0	0	0	597,294	597,294
5. 03	00550 CASHIERING/ACCOUNTS RECEIVABLE	0	0	0	752,045	752,045
5. 04	00560 OTHER ADMINISTRATIVE AND GENERAL	1,613,480	11,356,973	12,970,453	-5,168,870	7,801,583
7. 00	00700 OPERATION OF PLANT	294,217	1,317,816	1,612,033	484,575	2,096,608
8. 00	00800 LAUNDRY & LINEN SERVICE	0	113,435	113,435	0	113,435
9. 00	00900 HOUSEKEEPING	325,374	122,188	447,562	-7,555	440,007
10. 00	01000 DIETARY	954	984,387	985,341	-796,908	188,433
11. 00	01100 CAFETERIA	0	0	0	785,983	785,983
13. 00	01300 NURSING ADMINISTRATION	579,037	124,914	703,951	288,404	992,355
14. 00	01400 CENTRAL SERVICES & SUPPLY	163,588	228,845	392,433	581	393,014
15. 00	01500 PHARMACY	582,668	1,480,429	2,063,097	-1,320,781	742,316
16. 00	01600 MEDICAL RECORDS & LIBRARY	185,734	292,427	478,161	0	478,161
17. 00	01700 SOCIAL SERVICE	183,872	74,823	258,695	-115	258,580
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00	03000 ADULTS & PEDIATRICS	2,387,897	2,281,018	4,668,915	-1,117,089	3,551,826
31. 00	03100 INTENSIVE CARE UNIT	145,971	299,699	445,670	-228	445,442
43. 00	04300 NURSERY	0	0	0	584,937	584,937
44. 00	04400 SKILLED NURSING FACILITY	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS						
50. 00	05000 OPERATING ROOM	1,275,887	2,096,072	3,371,959	-589,049	2,782,910
51. 00	05100 RECOVERY ROOM	0	0	0	0	0
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	463,051	463,051
53. 00	05300 ANESTHESIOLOGY	0	0	0	0	0
54. 00	05400 RADIOLGY-DIAGNOSTIC	1,080,934	455,729	1,536,663	-240,347	1,296,316
54. 01	03630 ULTRA SOUND	0	0	0	0	0
56. 00	05600 RADIOSOTYPE	45,595	70,341	115,936	-1,052	114,884
57. 00	05700 CT SCAN	0	0	0	0	0
58. 00	05800 MRI	0	0	0	0	0
60. 00	06000 LABORATORY	1,005,271	1,217,930	2,223,201	-77,414	2,145,787
65. 00	06500 RESPIRATORY THERAPY	324,876	52,340	377,216	-1,871	375,345
66. 00	06600 PHYSICAL THERAPY	540,403	56,742	597,145	0	597,145
67. 00	06700 OCCUPATIONAL THERAPY	312,892	26,817	339,709	-4,228	335,481
68. 00	06800 SPEECH PATHOLOGY	151,110	11,261	162,371	0	162,371
69. 00	06900 ELECTROCARDIOLOGY	189,775	25,521	215,296	-242	215,054
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	102,062	102,062
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	253,023	253,023
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	1,139,765	1,139,765
76. 00	03950 OTHER ANCILLARY	0	0	0	0	0
76. 01	03951 SLEEP LAB	32,391	12,082	44,473	-205	44,268
76. 03	03953 WOUND CARE	63,740	14,367	78,107	0	78,107
OUTPATIENT SERVICE COST CENTERS						
90. 00	09000 CLINIC	0	0	0	0	0
91. 00	09100 EMERGENCY	912,116	1,735,292	2,647,408	-1,761	2,645,647
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)					
95. 00	09500 AMBULANCE SERVICES	107	8	115	-115	0
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	12,474,142	28,938,100	41,412,242	0	41,412,242
NONREIMBURSABLE COST CENTERS						
190. 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
192. 00	19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
194. 00	07950 OTHER NONREIMBURSABLE COST CENTER	0	0	0	0	0
194. 01	07955 MARKETING	0	0	0	0	0
194. 02	07952 SENIOR CITCLE	0	0	0	0	0
194. 03	07953 BUSINESS HEALTH	0	0	0	0	0
194. 04	07954 VACANT SPACE	0	0	0	0	0
200. 00	TOTAL (SUM OF LINES 118 through 199)	12,474,142	28,938,100	41,412,242	0	41,412,242
						200. 00

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	-79,678	1,757,738	1.00
2.00 00200	CAP REL COSTS-MVBL EQUIP	-830,677	2,642,755	2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	-472	2,728,646	4.00
5.01 01160	COMMUNITIES	-3,420	395,621	5.01
5.02 00540	ADMITTING	0	597,294	5.02
5.03 00550	CASHIERING/ACCOUNTS RECEIVABLE	0	752,045	5.03
5.04 00560	OTHER ADMINISTRATIVE AND GENERAL	-2,476,780	5,324,803	5.04
7.00 00700	OPERATION OF PLANT	-14,528	2,082,080	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	113,435	8.00
9.00 00900	HOUSEKEEPING	0	440,007	9.00
10.00 01000	DIETARY	0	188,433	10.00
11.00 01100	CAFETERIA	0	785,983	11.00
13.00 01300	NURSING ADMINISTRATION	-18,642	973,713	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	393,014	14.00
15.00 01500	PHARMACY	0	742,316	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	-157	478,004	16.00
17.00 01700	SOCIAL SERVICE	0	258,580	17.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00 03000	ADULTS & PEDIATRICS	-630,515	2,921,311	30.00
31.00 03100	INTENSIVE CARE UNIT	0	445,442	31.00
43.00 04300	NURSERY	0	584,937	43.00
44.00 04400	SKILLED NURSING FACILITY	0	0	44.00
ANCILLARY SERVICE COST CENTERS				
50.00 05000	OPERATING ROOM	-115,150	2,667,760	50.00
51.00 05100	RECOVERY ROOM	0	0	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	463,051	52.00
53.00 05300	ANESTHESIOLOGY	0	0	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	-26,563	1,269,753	54.00
54.01 03630	ULTRA SOUND	0	0	54.01
56.00 05600	RADIOISOTOPE	0	114,884	56.00
57.00 05700	CT SCAN	0	0	57.00
58.00 05800	MRI	0	0	58.00
60.00 06000	LABORATORY	0	2,145,787	60.00
65.00 06500	RESPIRATORY THERAPY	0	375,345	65.00
66.00 06600	PHYSICAL THERAPY	0	597,145	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	335,481	67.00
68.00 06800	SPEECH PATHOLOGY	0	162,371	68.00
69.00 06900	ELECTROCARDIOLOGY	0	215,054	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	102,062	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	253,023	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	1,139,765	73.00
76.00 03950	OTHER ANCILLARY	0	0	76.00
76.01 03951	SLEEP LAB	0	44,268	76.01
76.03 03953	WOUND CARE	0	78,107	76.03
OUTPATIENT SERVICE COST CENTERS				
90.00 09000	CLINIC	0	0	90.00
91.00 09100	EMERGENCY	-712,872	1,932,775	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
OTHER REIMBURSABLE COST CENTERS				
95.00 09500	AMBULANCE SERVICES	0	0	95.00
SPECIAL PURPOSE COST CENTERS				
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	-4,909,454	36,502,788	118.00
NONREIMBURSABLE COST CENTERS				
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
194.00 07950	OTHER NONREIMBURSABLE COST CENTER	0	0	194.00
194.01 07955	MARKETING	0	0	194.01
194.02 07952	SENIOR CIRCLE	0	0	194.02
194.03 07953	BUSINESS HEALTH	0	0	194.03
194.04 07954	VACANT SPACE	0	0	194.04
200.00	TOTAL (SUM OF LINES 118 through 199)	-4,909,454	36,502,788	200.00

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
A - RECLASS EMPLOYEE BENEFITS					
1.00	EMPLOYEE BENEFITS DEPARTMENT		4.00	0	2,589,095
	TOTALS			0	2,589,095
B - RECLASS RENTAL AND LEASE EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT		1.00	0	404,399
2.00	CAP REL COSTS-MVBL EQUIP		2.00	0	127,257
3.00	OTHER ADMINISTRATIVE AND GENERAL		5.04	0	620
4.00	CAP REL COSTS-BLDG & FIXT		1.00	0	1,251
5.00			0.00	0	0
6.00			0.00	0	0
7.00			0.00	0	0
8.00			0.00	0	0
9.00			0.00	0	0
10.00			0.00	0	0
11.00			0.00	0	0
	TOTALS			0	533,527
C - RECLASS OTHER CAPITAL COSTS					
1.00	CAP REL COSTS-BLDG & FIXT		1.00	0	156,806
2.00	CAP REL COSTS-BLDG & FIXT		1.00	0	191,710
3.00	CAP REL COSTS-MVBL EQUIP		2.00	0	7,488
	TOTALS			0	356,004
D - RECLASS REPAIRS & MAINTENANCE					
1.00	OPERATION OF PLANT		7.00	0	439,133
2.00			0.00	0	0
3.00			0.00	0	0
4.00			0.00	0	0
5.00			0.00	0	0
6.00			0.00	0	0
7.00			0.00	0	0
8.00			0.00	0	0
9.00			0.00	0	0
10.00			0.00	0	0
11.00			0.00	0	0
12.00			0.00	0	0
13.00			0.00	0	0
14.00			0.00	0	0
15.00			0.00	0	0
16.00			0.00	0	0
	TOTALS			0	439,133
E - RECLASS CNO COSTS					
1.00	NURSING ADMINISTRATION		13.00	288,412	0
	TOTALS			288,412	0
F - RECLASS MEDICAL SUPPLIES					
1.00	CENTRAL SERVICES & SUPPLY		14.00	0	107,760
2.00	MEDICAL SUPPLIES CHARGED TO PATIENT		71.00	0	102,062
3.00	IMPL. DEV. CHARGED TO PATIENTS		72.00	0	253,023
	TOTALS			0	462,845
G - RECLASS COST OF DRUGS/IV SOLUTIONS					
1.00	DRUGS CHARGED TO PATIENTS		73.00	0	1,139,765
	TOTALS			0	1,139,765
H - RECLASS LABOR AND DELIVERY COSTS					
1.00	NURSERY		43.00	300,121	284,816
2.00	DELIVERY ROOM & LABOR ROOM		52.00	237,584	225,467
	TOTALS			537,705	510,283
I - RECLASS A PORTION OF DIETARY TO CAFE					
1.00	CAFETERIA		11.00	761	785,222
	TOTALS			761	785,222
J - RECLASS ADMIN AND GENERAL COSTS					
1.00	COMMUNICATIONS		5.01	95,250	303,791
2.00	ADMINISTRATING		5.02	484,794	112,500
3.00	CASHIERING/ACCOUNTS RECEIVABLE		5.03	0	752,045
4.00	EMERGENCY		91.00	107	8
	TOTALS			580,151	1,168,344
K - NON-CAPITALIZED EQUIPMENT					
1.00	OPERATION OF PLANT		7.00	0	57,041
2.00	OTHER ADMINISTRATIVE AND GENERAL		5.04	0	1,088
3.00			0.00	0	0
4.00			0.00	0	0
5.00			0.00	0	0

Increases				
Cost Center	Line #	Salary	Other	
2.00	3.00	4.00	5.00	
TOTALS		0	58,129	
500.00	Grand Total: Increases	1,407,029	8,042,347	500.00

						Period: From 10/01/2021 To 09/30/2022	Worksheet A-6
						Date/Time Prepared: 2/28/2023 8:13 pm	
Decreases							
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - RECLASS EMPLOYEE BENEFITS						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	2,589,095	0		1.00
	TOTALS			0	2,589,095		
	B - RECLASS RENTAL AND LEASE EXPENSE						
1.00	OPERATION OF PLANT	7.00	0	11,599	10		1.00
2.00	NURSING ADMINISTRATION	13.00	0	8	10		2.00
3.00	CENTRAL SERVICES & SUPPLY	14.00	0	50,812	0		3.00
4.00	PHARMACY	15.00	0	153,813	10		4.00
5.00	ADULTS & PEDIATRICS	30.00	0	19,730	0		5.00
6.00	OPERATING ROOM	50.00	0	42,403	0		6.00
7.00	RADIOLOGY-DIAGNOSTIC	54.00	0	202,607	0		7.00
8.00	LABORATORY	60.00	0	49,797	0		8.00
9.00	RESPIRATORY THERAPY	65.00	0	1,302	0		9.00
10.00	SLEEP LAB	76.01	0	205	0		10.00
11.00	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	1,251	0		11.00
	TOTALS			0	533,527		
	C - RECLASS OTHER CAPITAL COSTS						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	356,004	12		1.00
2.00		0.00	0	0	13		2.00
3.00		0.00	0	0	12		3.00
	TOTALS			0	356,004		
	D - RECLASS REPAIRS & MAINTENANCE						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	937	0		1.00
2.00	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	178,750	0		2.00
3.00	HOUSEKEEPING	9.00	0	7,555	0		3.00
4.00	DIETARY	10.00	0	10,916	0		4.00
5.00	CENTRAL SERVICES & SUPPLY	14.00	0	56,367	0		5.00
6.00	PHARMACY	15.00	0	27,203	0		6.00
7.00	SOCIAL SERVICE	17.00	0	115	0		7.00
8.00	ADULTS & PEDIATRICS	30.00	0	5,265	0		8.00
9.00	INTENSIVE CARE UNIT	31.00	0	228	0		9.00
10.00	OPERATING ROOM	50.00	0	82,701	0		10.00
11.00	RADIOLOGY-DIAGNOSTIC	54.00	0	37,740	0		11.00
12.00	RADIOISOTOPES	56.00	0	1,052	0		12.00
13.00	LABORATORY	60.00	0	27,617	0		13.00
14.00	RESPIRATORY THERAPY	65.00	0	569	0		14.00
15.00	ELECTROCARDIOLOGY	69.00	0	242	0		15.00
16.00	EMERGENCY	91.00	0	1,876	0		16.00
	TOTALS			0	439,133		
	E - RECLASS CNO COSTS						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.04	288,412	0	0		1.00
	TOTALS		288,412	0	0		
	F - RECLASS MEDICAL SUPPLIES						
1.00	OPERATING ROOM	50.00	0	462,845	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	TOTALS		0	462,845	0		
	G - RECLASS COST OF DRUGS/IV SOLUTIONS						
1.00	PHARMACY	15.00	0	1,139,765	0		1.00
	TOTALS		0	1,139,765	0		
	H - RECLASS LABOR AND DELIVERY COSTS						
1.00	ADULTS & PEDIATRICS	30.00	537,705	510,283	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		537,705	510,283	0		
	I - RECLASS A PORTION OF DIETARY TO CAFE						
1.00	DIETARY	10.00	761	785,222	0		1.00
	TOTALS		761	785,222	0		
	J - RECLASS ADMINISTRATIVE AND GENERAL COSTS						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.04	580,044	1,168,336	0		1.00
2.00	AMBULANCE SERVICES	95.00	107	8	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
	TOTALS		580,151	1,168,344	0		
	K - NON-CAPITALIZED EQUIPMENT						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	8,686	0		1.00
2.00	DIETARY	10.00	0	9	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	44,106	0		3.00

Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.
4.00	OPERATING ROOM	6.00	50.00	0	1,100
5.00	OCCUPATIONAL THERAPY	67.00	67.00	0	4,228
	TOTALS			0	58,129
500.00	Grand Total: Decreases		1,407,029	8,042,347	500.00

		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	3,844,900	0	0	0	9,700	1.00
2.00	Land Improvements	719,024	0	0	0	36,231	2.00
3.00	Buildings and Fixtures	20,253,214	0	0	0	2,259,459	3.00
4.00	Building Improvements	7,383,569	895,516	0	895,516	123,734	4.00
5.00	Fixed Equipment	2,491,374	1,403,683	0	1,403,683	243,346	5.00
6.00	Movable Equipment	17,189,966	14,146,859	0	14,146,859	565,712	6.00
7.00	HIT designated Assets	5,591,294	0	0	0	2,106,513	7.00
8.00	Subtotal (sum of lines 1-7)	57,473,341	16,446,058	0	16,446,058	5,344,695	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	57,473,341	16,446,058	0	16,446,058	5,344,695	10.00
		Ending Balance	Fully Depreciated Assets				
			6.00	7.00			
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	3,835,200	0	0	0	0	1.00
2.00	Land Improvements	682,793	0	0	0	0	2.00
3.00	Buildings and Fixtures	17,993,755	0	0	0	0	3.00
4.00	Building Improvements	8,155,351	0	0	0	0	4.00
5.00	Fixed Equipment	3,651,711	0	0	0	0	5.00
6.00	Movable Equipment	30,771,113	0	0	0	0	6.00
7.00	HIT designated Assets	3,484,781	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	68,574,704	0	0	0	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	68,574,704	0	0	0	0	10.00

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	1,083,250	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	3,338,687	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	4,421,937	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other	Total (1) (sum of cols. 9 through 14)				
		Capital-Related Costs (see instructions)					
		14.00	15.00				
PART III - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	0	1,083,250				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	3,338,687				2.00
3.00	Total (sum of lines 1-2)	0	4,421,937				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0075

Period:

From 10/01/2021

To 09/30/2022

Worksheet A-7

Part III

Date/Time Prepared:

2/28/2023 8:13 pm

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	30,667,099	0	30,667,099	0.447207	0	1.00
2.00	CAP REL COSTS-MVBL EQUIP	37,907,605	0	37,907,605	0.552793	0	2.00
3.00	Total (sum of lines 1-2)	68,574,704	0	68,574,704	1.000000	0	3.00
ALLOCATION OF OTHER CAPITAL							
Cost Center Description		Taxes	Other Capital -Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
					SUMMARY OF CAPITAL		
Cost Center Description		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital -Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
					SUMMARY OF CAPITAL		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	156,806	191,710	118,229	1,757,738	1.00
2.00	CAP REL COSTS-MVBL EQUIP	0	7,488	0	625	2,642,755	2.00
3.00	Total (sum of lines 1-2)	0	164,294	191,710	118,854	4,400,493	3.00

			Period: From 10/01/2021 To 09/30/2022	Worksheet A-8	
			Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		
Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.
			1.00	2.00	3.00
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0CAP REL COSTS-BLDG & FIXT	1.00	0 1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0CAP REL COSTS-MVBLE EQUIP	2.00	0 2.00
3.00	Investment income - other (chapter 2)	0	0	0.00	0 3.00
4.00	Trade, quantity, and time discounts (chapter 8)	0	0	0.00	0 4.00
5.00	Refunds and rebates of expenses (chapter 8)	0	0	0.00	0 5.00
6.00	Rental of provider space by suppliers (chapter 8)	0	0	0.00	0 6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-1,703 COMMUNICATIONS	5.01	0 7.00
8.00	Television and radio service (chapter 21)	A	-14,528 OPERATION OF PLANT	7.00	0 8.00
9.00	Parking lot (chapter 21)		0	0.00	0 9.00
10.00	Provider-based physician adjustment	A-8-2	-1,481,208	0	0 10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0	0.00	0 11.00
12.00	Related organizations transactions (chapter 10)	A-8-1	273,710		0 12.00
13.00	Laundry and linen service		0	0.00	0 13.00
14.00	Cafeteria-employees and guests		0	0.00	0 14.00
15.00	Rental of quarters to employee and others		0	0.00	0 15.00
16.00	Sale of medical and surgical supplies to other than patients		0	0.00	0 16.00
17.00	Sale of drugs to other than patients		0	0.00	0 17.00
18.00	Sale of medical records and abstracts	B	-157 MEDICAL RECORDS & LIBRARY	16.00	0 18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0	0.00	0 19.00
20.00	Vending machines	B	15 OTHER ADMINISTRATIVE AND GENERAL	5.04	0 20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0	0.00	0 21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0	0.00	0 22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0 RESPIRATORY THERAPY	65.00	23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0 PHYSICAL THERAPY	66.00	24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0 *** Cost Center Deleted ***	114.00	25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT	A	-71,373 CAP REL COSTS-BLDG & FIXT	1.00	9 26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	A	-905,813 CAP REL COSTS-MVBLE EQUIP	2.00	9 27.00
28.00	Non-physician Anesthetist		0 *** Cost Center Deleted ***	19.00	28.00
29.00	Physicians' assistant		0	0.00	0 29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0 OCCUPATIONAL THERAPY	67.00	30.00
30.99	Hospice (non-distinct) (see instructions)	A	-3,892 ADULTS & PEDIATRICS	30.00	30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0 SPEECH PATHOLOGY	68.00	31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0	0.00	0 32.00

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			Wkst. A-7 Ref.	
				Cost Center	Line #			
				1.00	2.00	3.00	4.00	5.00
33.00	INSERVICE EDUCATION	B	-18,842	NURSING ADMINISTRATION		13.00	0	33.00
33.01	FITNESS REVENUE	B	-7,640	OTHER ADMINISTRATIVE AND GENERAL		5.04	0	33.01
33.02	OTHER MIS REVENUE	B	-7,096	OTHER ADMINISTRATIVE AND GENERAL		5.04	0	33.02
33.03	PATIENT PHONES BENEFITS	A	-472	EMPLOYEE BENEFITS DEPARTMENT		4.00	0	33.03
33.04	TRAINING REVENUE	B	200	NURSING ADMINISTRATION		13.00	0	33.04
33.05	PHYSICAL RECRUITING	A	-122	OTHER ADMINISTRATIVE AND GENERAL		5.04	0	33.05
33.06	CHARITABLE CONTRIBUTIONS	A	-31,750	OTHER ADMINISTRATIVE AND GENERAL		5.04	0	33.06
33.07	CRNA COSTS	A	-454,218	OTHER ADMINISTRATIVE AND GENERAL		5.04	0	33.07
33.09	PENALTIES/LATE FEES	A	-368	OTHER ADMINISTRATIVE AND GENERAL		5.04	0	33.09
33.11	LEGAL FEES	A	-37,646	OTHER ADMINISTRATIVE AND GENERAL		5.04	0	33.11
33.12	MARKETING DEPARTMENT	A	-31,140	OTHER ADMINISTRATIVE AND GENERAL		5.04	0	33.12
33.13	PROVIDER TAX EXPENSE	A	-1,951,681	OTHER ADMINISTRATIVE AND GENERAL		5.04	0	33.13
33.14	RENTAL INCOME	B	-162,013	CAP REL COSTS-BLDG & FIXT		1.00	9	33.14
33.15	PATIENT PHONE WAGES	A	-1,717	COMMUNICATIONS		5.01	0	33.15
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-4,909,454					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: 15-0075	Period: From 10/01/2021 To 09/30/2022	Worksheet A-8-1
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	Line No.	Cost Center	Expense Items	Amount of	Amount
				All allowable Cost	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 CLAIMS HOME OFFICE COSTS:					
1. 00	1. 00	CAP REL COSTS-BLDG & FIXT	CAPITAL-RELATED INTEREST	115, 239	0 1. 00
2. 00	1. 00	CAP REL COSTS-BLDG & FIXT	PASI CAPITAL COSTS - BLDG &	2, 990	0 2. 00
3. 00	2. 00	CAP REL COSTS-MVBLE EQUIP	PASI CAPITAL COSTS - MOVEABL	625	0 3. 00
4. 00	5. 04	OTHER ADMINISTRATIVE AND GEN	PASI OPERATING COSTS	213, 570	164, 767 4. 00
4. 01	5. 04	OTHER ADMINISTRATIVE AND GEN	SHARED SERVICE CENTER ALLOCA	994, 733	645, 684 4. 01
4. 02	1. 00	CAP REL COSTS-BLDG & FIXT	NEW CAPITAL - BUILDING & FIX	35, 479	0 4. 02
4. 03	2. 00	CAP REL COSTS-MVBLE EQUIP	NEW CAPITAL - MOVABLE EQUIPM	74, 511	0 4. 03
4. 04	5. 04	OTHER ADMINISTRATIVE AND GEN	NON-CAPITAL HOME OFFICE COST	1, 386, 849	0 4. 04
4. 05	5. 04	OTHER ADMINISTRATIVE AND GEN	MALPRACTICE COSTS	230, 522	181, 551 4. 05
4. 06	5. 04	OTHER ADMINISTRATIVE AND GEN	MANAGEMENT FEES	0	837, 954 4. 06
4. 07	5. 04	OTHER ADMINISTRATIVE AND GEN	401K FEES	0	4, 775 4. 07
4. 08	5. 04	OTHER ADMINISTRATIVE AND GEN	AUDIT FEES	0	27, 993 4. 08
4. 09	5. 04	OTHER ADMINISTRATIVE AND GEN	CORPORATE OVERHEAD ALLOCATIO	0	575, 809 4. 09
4. 10	5. 04	OTHER ADMINISTRATIVE AND GEN	HIM ALLOCATION	0	254, 954 4. 10
4. 11	5. 04	OTHER ADMINISTRATIVE AND GEN	CONTRACT MANAGEMENT	0	73, 388 4. 11
4. 12	5. 04	OTHER ADMINISTRATIVE AND GEN	PASI LIEN UNIT COLLECTION FE	0	13, 933 4. 12
5. 00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			3, 054, 518	2, 780, 808 5. 00

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

Symbol (1)	Name	Percentage of Ownership	Related Organization(s) and/or Home Office		
			1. 00	2. 00	3. 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 requested information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

6. 00	B	CHS, INC.	100. 00	CHS, INC.	100. 00	6. 00
7. 00	B	PASI	100. 00	PASI	100. 00	7. 00
8. 00			0. 00		0. 00	8. 00
9. 00			0. 00		0. 00	9. 00
10. 00			0. 00		0. 00	10. 00
100. 00	G. Other (financial or non-financial) specify:					100. 00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

Provider CCN: 15-0075

Period:
From 10/01/2021
To 09/30/2022Worksheet A-8-1
Date/Time Prepared:
2/28/2023 8:13 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.	
	6.00	7.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	115,239	14	1.00
2.00	2,990	14	2.00
3.00	625	14	3.00
4.00	48,803	0	4.00
4.01	349,049	0	4.01
4.02	35,479	9	4.02
4.03	74,511	9	4.03
4.04	1,386,849	0	4.04
4.05	48,971	0	4.05
4.06	-837,954	0	4.06
4.07	-4,775	0	4.07
4.08	-27,993	0	4.08
4.09	-575,809	0	4.09
4.10	-254,954	0	4.10
4.11	-73,388	0	4.11
4.12	-13,933	0	4.12
5.00	273,710		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 ORGANIZATIONS 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 requested information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

6.00	HOSPITAL MANAGE	6.00
7.00	COLLECTIONS	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: 15-0075

Worksheet A-8-2

Period:
From 10/01/2021
To 09/30/2022

Date/Time Prepared:
2/28/2023 8:13 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours
	1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	7. 00
1. 00	30. 00	ADULTS & PEDIATRICS	626, 623	626, 623	0	0	0
2. 00	50. 00	OPERATING ROOM	115, 150	115, 150	0	0	2. 00
3. 00	54. 00	RADIOLOGY-DIAGNOSTIC	26, 563	26, 563	0	0	3. 00
4. 00	91. 00	EMERGENCY	712, 872	712, 872	0	0	4. 00
5. 00	0. 00		0	0	0	0	5. 00
6. 00	0. 00		0	0	0	0	6. 00
7. 00	0. 00		0	0	0	0	7. 00
8. 00	0. 00		0	0	0	0	8. 00
9. 00	0. 00		0	0	0	0	9. 00
10. 00	0. 00		0	0	0	0	10. 00
200. 00			1, 481, 208	1, 481, 208	0	0	200. 00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance
	1. 00	2. 00	8. 00	9. 00	12. 00	13. 00	14. 00
1. 00	30. 00	ADULTS & PEDIATRICS	0	0	0	0	0
2. 00	50. 00	OPERATING ROOM	0	0	0	0	2. 00
3. 00	54. 00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	3. 00
4. 00	91. 00	EMERGENCY	0	0	0	0	4. 00
5. 00	0. 00		0	0	0	0	5. 00
6. 00	0. 00		0	0	0	0	6. 00
7. 00	0. 00		0	0	0	0	7. 00
8. 00	0. 00		0	0	0	0	8. 00
9. 00	0. 00		0	0	0	0	9. 00
10. 00	0. 00		0	0	0	0	10. 00
200. 00			0	0	0	0	200. 00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	1. 00	2. 00	15. 00	16. 00	17. 00	18. 00	
1. 00	30. 00	ADULTS & PEDIATRICS	0	0	0	626, 623	1. 00
2. 00	50. 00	OPERATING ROOM	0	0	0	115, 150	2. 00
3. 00	54. 00	RADIOLOGY-DIAGNOSTIC	0	0	0	26, 563	3. 00
4. 00	91. 00	EMERGENCY	0	0	0	712, 872	4. 00
5. 00	0. 00		0	0	0	0	5. 00
6. 00	0. 00		0	0	0	0	6. 00
7. 00	0. 00		0	0	0	0	7. 00
8. 00	0. 00		0	0	0	0	8. 00
9. 00	0. 00		0	0	0	0	9. 00
10. 00	0. 00		0	0	0	0	10. 00
200. 00			0	0	0	1, 481, 208	200. 00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0075

Period:
From 10/01/2021
To 09/30/2022Worksheet B
Part I
Date/Time Prepared:
2/28/2023 8:13 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	COMMUNICATIONS	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00	2.00	4.00	5.01
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	1,757,738	1,757,738			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	2,642,755	2,642,755			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	2,728,646	6,622	9,956	2,745,224	4.00
5.01 01160	COMMUNICATIONS	395,621	4,058	6,102	21,091	5.01
5.02 00540	ADMITTING	597,294	7,491	11,263	107,346	5.02
5.03 00550	CASHIERING/ACCOUNTS RECEIVABLE	752,045	10,354	15,567	0	5.03
5.04 00560	OTHER ADMINISTRATIVE AND GENERAL	5,324,803	176,850	265,893	164,968	5.04
7.00 00700	OPERATION OF PLANT	2,082,080	651,265	979,175	65,148	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	113,435	0	0	0	8.00
9.00 00900	HOUSEKEEPING	440,007	8,406	12,639	72,047	9.00
10.00 01000	DIETARY	188,433	47,784	71,843	43	10.00
11.00 01100	CAFETERIA	785,983	0	0	169	11.00
13.00 01300	NURSING ADMINISTRATION	973,713	8,678	13,047	192,077	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	393,014	34,740	52,231	36,223	14.00
15.00 01500	PHARMACY	742,316	14,784	22,227	129,018	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	478,004	56,670	85,204	41,127	16.00
17.00 01700	SOCIAL SERVICE	258,580	1,540	2,315	40,714	0
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	2,921,311	331,117	497,834	409,677	30.00
31.00 03100	INTENSIVE CARE UNIT	445,442	19,666	29,568	32,322	31.00
43.00 04300	NURSERY	584,937	0	0	66,455	43.00
44.00 04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	2,667,760	120,977	181,888	282,516	50.00
51.00 05100	RECOVERY ROOM	0	0	0	0	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	463,051	0	0	52,608	52.00
53.00 05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	1,269,753	98,330	147,840	239,348	54.00
54.01 03630	ULTRA SOUND	0	0	0	0	54.01
56.00 05600	RADIOISOTOPE	114,884	5,209	7,831	10,096	56.00
57.00 05700	CT SCAN	0	0	0	0	57.00
58.00 05800	MRI	0	0	0	0	58.00
60.00 06000	LABORATORY	2,145,787	40,256	60,525	222,594	60.00
65.00 06500	RESPIRATORY THERAPY	375,345	6,966	10,473	71,936	65.00
66.00 06600	PHYSICAL THERAPY	597,145	54,215	81,513	119,660	66.00
67.00 06700	OCCUPATIONAL THERAPY	335,481	0	0	69,283	67.00
68.00 06800	SPEECH PATHOLOGY	162,371	0	0	33,460	68.00
69.00 06900	ELECTROCARDIOLOGY	215,054	4,964	7,463	42,021	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	102,062	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	253,023	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	1,139,765	0	0	0	73.00
76.00 03950	OTHER ANCILLARY	0	0	0	0	76.00
76.01 03951	SLEEP LAB	44,268	4,946	7,436	7,172	76.01
76.03 03953	WOUND CARE	78,107	0	0	14,114	76.03
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	0	0	0	90.00
91.00 09100	EMERGENCY	1,932,775	41,850	62,922	201,991	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500	AMBULANCE SERVICES	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	36,502,788	1,757,738	2,642,755	2,745,224	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GI FT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	2,591
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	246,794
194.00 07950	OTHER NONREIMBURSABLE COST CENTER	0	0	0	0	194.00
194.01 07955	MARKETING	0	0	0	0	194.01
194.02 07952	SENIOR CITCLE	0	0	0	0	194.02
194.03 07953	BUSINESS HEALTH	0	0	0	0	194.03
194.04 07954	VACANT SPACE	0	0	0	0	194.04
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers					201.00
202.00	TOTAL (sum lines 118 through 201)	36,502,788	1,757,738	2,642,755	2,745,224	426,872
						202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0075

Period:
From 10/01/2021
To 09/30/2022Worksheet B
Part I
Date/Time Prepared:
2/28/2023 8:13 pm

Cost Center Description	Subtotal	ADMITTING	Subtotal	CASHIERING/ACCOUNTS RECEIVABLE	Subtotal	
GENERAL SERVICE COST CENTERS						
1. 00 00100	CAP REL COSTS-BLDG & FIXT					1. 00
2. 00 00200	CAP REL COSTS-MVBL EQUIP					2. 00
4. 00 00400	EMPLOYEE BENEFITS DEPARTMENT					4. 00
5. 01 01160	COMMUNICATIONS					5. 01
5. 02 00540	ADMITTING	730, 519	730, 519			5. 02
5. 03 00550	CASHIERING/ACCOUNTS RECEIVABLE	783, 148	15, 993	799, 141	799, 141	5. 03
5. 04 00560	OTHER ADMINISTRATIVE AND GENERAL	5, 966, 197	121, 848	6, 088, 045	136, 255	6, 224, 300
7. 00 00700	OPERATION OF PLANT	3, 785, 441	77, 302	3, 862, 743	86, 460	3, 949, 203
8. 00 00800	LAUNDRY & LINEN SERVICE	114, 083	2, 330	116, 413	2, 606	119, 019
9. 00 00900	HOUSEKEEPING	534, 395	10, 913	545, 308	12, 206	557, 514
10. 00 01000	DIETARY	313, 933	6, 411	320, 344	7, 170	327, 514
11. 00 01100	CAFETERIA	786, 152	16, 054	802, 206	17, 956	820, 162
13. 00 01300	NURSING ADMINISTRATION	1, 189, 458	24, 290	1, 213, 748	27, 167	1, 240, 915
14. 00 01400	CENTRAL SERVICES & SUPPLY	519, 447	10, 608	530, 055	11, 864	541, 919
15. 00 01500	PHARMACY	915, 470	18, 695	934, 165	20, 909	955, 074
16. 00 01600	MEDICAL RECORDS & LIBRARY	677, 199	13, 829	691, 028	15, 467	706, 495
17. 00 01700	SOCIAL SERVICE	303, 149	6, 191	309, 340	6, 924	316, 264
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000	ADULTS & PEDIATRICS	4, 172, 894	85, 215	4, 258, 109	95, 309	4, 353, 418
31. 00 03100	INTENSIVE CARE UNIT	530, 237	10, 828	541, 065	12, 111	553, 176
43. 00 04300	NURSERY	652, 040	13, 315	665, 355	14, 893	680, 248
44. 00 04400	SKILLED NURSING FACILITY	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS						
50. 00 05000	OPERATING ROOM	3, 275, 165	66, 882	3, 342, 047	74, 805	3, 416, 852
51. 00 05100	RECOVERY ROOM	0	0	0	0	0
52. 00 05200	DELIVERY ROOM & LABOR ROOM	516, 955	10, 557	527, 512	11, 807	539, 319
53. 00 05300	ANESTHESIOLOGY	0	0	0	0	0
54. 00 05400	RADIOLOGY-DIAGNOSTIC	1, 768, 874	36, 122	1, 804, 996	40, 401	1, 845, 397
54. 01 03630	ULTRA SOUND	0	0	0	0	0
56. 00 05600	RADIOISOTOPES	139, 316	2, 845	142, 161	3, 182	145, 343
57. 00 05700	CT SCAN	0	0	0	0	0
58. 00 05800	MRI	0	0	0	0	0
60. 00 06000	LABORATORY	2, 481, 469	50, 674	2, 532, 143	56, 677	2, 588, 820
65. 00 06500	RESPIRATORY THERAPY	466, 663	9, 530	476, 193	10, 659	486, 852
66. 00 06600	PHYSICAL THERAPY	855, 772	17, 476	873, 248	19, 546	892, 794
67. 00 06700	OCCUPATIONAL THERAPY	404, 764	8, 266	413, 030	9, 245	422, 275
68. 00 06800	SPEECH PATHOLOGY	195, 831	3, 999	199, 830	4, 473	204, 303
69. 00 06900	ELECTROCARDIOLOGY	273, 389	5, 583	278, 972	6, 244	285, 216
71. 00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	102, 062	2, 084	104, 146	2, 331	106, 477
72. 00 07200	IMPL. DEV. CHARGED TO PATIENTS	253, 023	5, 167	258, 190	5, 779	263, 969
73. 00 07300	DRUGS CHARGED TO PATIENTS	1, 139, 765	23, 275	1, 163, 040	26, 032	1, 189, 072
76. 00 03950	OTHER ANCILLARY	0	0	0	0	0
76. 01 03951	SLEEP LAB	63, 822	1, 303	65, 125	1, 458	66, 583
76. 03 03953	WOUND CARE	92, 221	1, 883	94, 104	2, 106	96, 210
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000	CLINIC	0	0	0	0	0
91. 00 09100	EMERGENCY	2, 250, 550	45, 958	2, 296, 508	51, 403	2, 347, 911
92. 00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500	AMBULANCE SERVICES	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS						
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	36, 253, 403	725, 426	36, 248, 310	793, 445	36, 242, 614
NONREIMBURSABLE COST CENTERS						
190. 00 19000	GI FT, FLOWER, COFFEE SHOP & CANTEEN	2, 591	53	2, 644	59	2, 703
192. 00 19200	PHYSICIANS' PRIVATE OFFICES	246, 794	5, 040	251, 834	5, 637	257, 471
194. 00 07950	OTHER NONREIMBURSABLE COST CENTER	0	0	0	0	0
194. 01 07955	MARKETING	0	0	0	0	0
194. 02 07952	SENIOR CITCLE	0	0	0	0	0
194. 03 07953	BUSINESS HEALTH	0	0	0	0	0
194. 04 07954	VACANT SPACE	0	0	0	0	0
200. 00	Cross Foot Adjustments	0	0	0	0	0
201. 00	Negative Cost Centers	0	0	0	0	0
202. 00	TOTAL (sum lines 118 through 201)	36, 502, 788	730, 519	36, 502, 788	799, 141	36, 502, 788
						202. 00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0075

Period:
From 10/01/2021
To 09/30/2022Worksheet B
Part I
Date/Time Prepared:
2/28/2023 8:13 pm

Cost Center Description	OTHER ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBL EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01 01160	COMMUNITIES					5.01
5.02 00540	ADMINISTERING					5.02
5.03 00550	CASHIERING/ACCOUNTS RECEIVABLE					5.03
5.04 00560	OTHER ADMINISTRATIVE AND GENERAL	6,224,300				5.04
7.00 00700	OPERATION OF PLANT	811,830	4,761,033			7.00
8.00 00800	LAUNDRY & LINEN SERVICE	24,466	0	143,485		8.00
9.00 00900	HOUSEKEEPING	114,607	44,416	0	716,537	9.00
10.00 01000	DIETARY	67,326	252,470	0	38,355	685,665
11.00 01100	CAFETERIA	168,599	0	0	0	10.00
13.00 01300	NURSING ADMINISTRATION	255,092	45,851	0	6,966	11.00
14.00 01400	CENTRAL SERVICES & SUPPLY	111,401	183,549	0	27,884	13.00
15.00 01500	PHARMACY	196,333	78,110	0	11,866	14.00
16.00 01600	MEDICAL RECORDS & LIBRARY	145,233	299,422	0	45,487	15.00
17.00 01700	SOCIAL SERVICE	65,014	8,136	0	1,236	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	894,936	1,749,485	56,709	265,779	685,665
31.00 03100	INTENSIVE CARE UNIT	113,715	103,908	80	15,785	30.00
43.00 04300	NURSERY	139,837	0	0	0	31.00
44.00 04400	SKILLED NURSING FACILITY	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	702,395	639,192	26,078	97,104	0
51.00 05100	RECOVERY ROOM	0	0	0	0	50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	110,867	0	0	0	51.00
53.00 05300	ANESTHESIOLOGY	0	0	0	0	52.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	379,355	519,538	18,584	78,927	0
54.01 03630	ULTRA SOUND	0	0	0	0	54.00
56.00 05600	RADIOISOTOPES	29,878	27,520	0	4,181	0
57.00 05700	CT SCAN	0	0	0	0	55.00
58.00 05800	MRI	0	0	0	0	56.00
60.00 06000	LABORATORY	532,179	212,697	0	32,312	0
65.00 06500	RESPIRATORY THERAPY	100,081	36,806	1,287	5,591	0
66.00 06600	PHYSICAL THERAPY	183,530	286,452	301	43,517	0
67.00 06700	OCCUPATIONAL THERAPY	86,806	0	2,640	0	66.00
68.00 06800	SPEECH PATHOLOGY	41,998	0	0	0	67.00
69.00 06900	ELECTROCARDIOLOGY	58,631	26,228	0	3,985	0
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	21,888	0	0	0	68.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	54,264	0	0	0	71.00
73.00 07300	DRUGS CHARGED TO PATIENTS	244,435	0	0	0	72.00
76.00 03950	OTHER ANCILLARY	0	0	0	0	73.00
76.01 03951	SLEEP LAB	13,687	26,132	0	3,970	0
76.03 03953	WOUND CARE	19,778	0	4,641	0	76.01
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	0	0	0	0
91.00 09100	EMERGENCY	482,655	221,121	33,165	33,592	90.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					91.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500	AMBULANCE SERVICES	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)		6,170,816	4,761,033	143,485	716,537
	NONREIMBURSABLE COST CENTERS					685,665
190.00 19000	GI FT, FLOWER, COFFEE SHOP & CANTEEN	556	0	0	0	118.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	52,928	0	0	0	190.00
194.00 07950	OTHER NONREIMBURSABLE COST CENTER	0	0	0	0	192.00
194.01 07955	MARKETING	0	0	0	0	194.00
194.02 07952	SENIOR CITCLE	0	0	0	0	194.01
194.03 07953	BUSINESS HEALTH	0	0	0	0	194.02
194.04 07954	VACANT SPACE	0	0	0	0	194.03
200.00	Cross Foot Adjustments					194.04
201.00	Negative Cost Centers	0	0	0	0	200.00
202.00	TOTAL (sum lines 118 through 201)	6,224,300	4,761,033	143,485	716,537	685,665
						202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0075

Period:
From 10/01/2021
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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-MVBL EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01 01160	COMMUNICATIONS					5.01
5.02 00540	ADMITTING					5.02
5.03 00550	CASHIERING/ACCOUNTS RECEIVABLE					5.03
5.04 00560	OTHER ADMINISTRATIVE AND GENERAL					5.04
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	988,761				11.00
13.00 01300	NURSING ADMINISTRATION	40,926	1,589,750			13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	26,433	0	891,186		14.00
15.00 01500	PHARMACY	41,827	0	35,053	1,318,263	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	25,307	0	202	0	16.00
17.00 01700	SOCIAL SERVICE	17,422	0	400	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	172,416	750,340	63,887	0	78,423
31.00 03100	INTENSIVE CARE UNIT	11,790	49,074	388	0	3,330
43.00 04300	NURSERY	25,156	0	0	0	5,181
44.00 04400	SKILLED NURSING FACILITY	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	114,068	402,169	277,817	0	193,640
51.00 05100	RECOVERY ROOM	0	0	0	0	0
52.00 05200	DELIVERY ROOM & LABOR ROOM	19,900	0	0	0	4,101
53.00 05300	ANESTHESIOLOGY	0	0	0	0	0
54.00 05400	RADIOLOGY-DIAGNOSTIC	109,937	3,382	35,665	0	233,848
54.01 03630	ULTRA SOUND	0	0	0	0	0
56.00 05600	RADIOISOTOPES	5,332	0	19,675	0	7,560
57.00 05700	CT SCAN	0	0	0	0	0
58.00 05800	MRI	0	0	0	0	0
60.00 06000	LABORATORY	135,319	0	205,690	0	265,992
65.00 06500	RESPIRATORY THERAPY	31,089	0	11,983	0	19,610
66.00 06600	PHYSICAL THERAPY	57,822	0	5,403	0	25,573
67.00 06700	OCCUPATIONAL THERAPY	34,543	0	1,227	0	20,640
68.00 06800	SPEECH PATHOLOGY	13,292	0	349	0	7,028
69.00 06900	ELECTROCARDIOLOGY	19,975	61,369	1,364	0	43,517
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	77,525	0	63,452
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	113,951	0	20,831
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,318,263	93,356
76.00 03950	OTHER ANCILLARY	0	0	0	0	0
76.01 03951	SLEEP LAB	2,703	0	1,592	0	2,425
76.03 03953	WOUND CARE	7,359	20,925	3,810	0	2,267
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	0	0	0	1,181
91.00 09100	EMERGENCY	76,145	302,491	35,205	0	130,191
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500	AMBULANCE SERVICES	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS						
118.00	Subtotals (sum of lines 1 through 117)	988,761	1,589,750	891,186	1,318,263	1,222,146
NONREIMBURSABLE COST CENTERS						
190.00 19000	GI FT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
194.00 07950	OTHER NONREIMBURSABLE COST CENTER	0	0	0	0	0
194.01 07955	MARKETING	0	0	0	0	0
194.02 07952	SENIOR CITCLE	0	0	0	0	0
194.03 07953	BUSINESS HEALTH	0	0	0	0	0
194.04 07954	VACANT SPACE	0	0	0	0	0
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers	0	0	0	0	0
202.00	TOTAL (sum lines 118 through 201)	988,761	1,589,750	891,186	1,318,263	1,222,146
						202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0075

Period:

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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-MVBL EQUIP					2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	01160 COMMUNITIES					5.01
5.02	00540 ADMITTING					5.02
5.03	00550 CASHIERING/ACCOUNTS RECEIVABLE					5.03
5.04	00560 OTHER ADMITTING AND GENERAL					5.04
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	408,472				17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	350,889	9,421,947	0	9,421,947	30.00
31.00	03100 INTENSIVE CARE UNIT	10,570	861,816	0	861,816	31.00
43.00	04300 NURSERY	47,013	897,435	0	897,435	43.00
44.00	04400 SKILLED NURSING FACILITY	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	5,869,315	0	5,869,315	50.00
51.00	05100 RECOVERY ROOM	0	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	674,187	0	674,187	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400 RADIOLYSIS-DIAGNOSTIC	0	3,224,633	0	3,224,633	54.00
54.01	03630 ULTRA SOUND	0	0	0	0	54.01
56.00	05600 RADIOSCOPE	0	239,489	0	239,489	56.00
57.00	05700 CT SCAN	0	0	0	0	57.00
58.00	05800 MRI	0	0	0	0	58.00
60.00	06000 LABORATORY	0	3,973,009	0	3,973,009	60.00
65.00	06500 RESPIRATORY THERAPY	0	693,299	0	693,299	65.00
66.00	06600 PHYSICAL THERAPY	0	1,495,392	0	1,495,392	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	568,131	0	568,131	67.00
68.00	06800 SPEECH PATHOLOGY	0	266,970	0	266,970	68.00
69.00	06900 ELECTROCARDIOLOGY	0	500,285	0	500,285	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	269,342	0	269,342	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	453,015	0	453,015	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	2,845,126	0	2,845,126	73.00
76.00	03950 OTHER ANCILLARY	0	0	0	0	76.00
76.01	03951 SLEEP LAB	0	117,092	0	117,092	76.01
76.03	03953 WOUND CARE	0	154,990	0	154,990	76.03
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	0	1,181	0	1,181	90.00
91.00	09100 EMERGENCY	0	3,662,476	0	3,662,476	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	408,472	36,189,130	0	36,189,130	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3,259	0	3,259	190.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	310,399	0	310,399	192.00
194.00	07950 OTHER NONREIMBURSABLE COST CENTER	0	0	0	0	194.00
194.01	07955 MARKETING	0	0	0	0	194.01
194.02	07952 SENIOR CITI CLE	0	0	0	0	194.02
194.03	07953 BUSINESS HEALTH	0	0	0	0	194.03
194.04	07954 VACANT SPACE	0	0	0	0	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)	408,472	36,502,788	0	36,502,788	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0075

Period:

From 10/01/2021

To 09/30/2022

Worksheet B

Part II

Date/Time Prepared:

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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS			Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	MVBLE EQUIP				
		0	1.00	2.00			
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	6,622	9,956	16,578	16,578	4.00
5.01 01160	COMMUNICATIONS	0	4,058	6,102	10,160	127	5.01
5.02 00540	ADMITTING	0	7,491	11,263	18,754	648	5.02
5.03 00550	CASHIERING/ACCOUNTS RECEIVABLE	0	10,354	15,567	25,921	0	5.03
5.04 00560	OTHER ADMINISTRATIVE AND GENERAL	0	176,850	265,893	442,743	996	5.04
7.00 00700	OPERATION OF PLANT	0	651,265	979,175	1,630,440	393	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00 00900	HOUSEKEEPING	0	8,406	12,639	21,045	435	9.00
10.00 01000	DIETARY	0	47,784	71,843	119,627	0	10.00
11.00 01100	CAFETERIA	0	0	0	0	1	11.00
13.00 01300	NURSING ADMINISTRATION	0	8,678	13,047	21,725	1,160	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	34,740	52,231	86,971	219	14.00
15.00 01500	PHARMACY	0	14,784	22,227	37,011	779	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	56,670	85,204	141,874	248	16.00
17.00 01700	SOCIAL SERVICE	0	1,540	2,315	3,855	246	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000	ADULTS & PEDIATRICS	0	331,117	497,834	828,951	2,477	30.00
31.00 03100	INTENSIVE CARE UNIT	0	19,666	29,568	49,234	195	31.00
43.00 04300	NURSERY	0	0	0	0	401	43.00
44.00 04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00 05000	OPERATING ROOM	0	120,977	181,888	302,865	1,706	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	318	52.00
53.00 05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	98,330	147,840	246,170	1,445	54.00
54.01 03630	ULTRA SOUND	0	0	0	0	0	54.01
56.00 05600	RADIOISOTOPES	0	5,209	7,831	13,040	61	56.00
57.00 05700	CT SCAN	0	0	0	0	0	57.00
58.00 05800	MRI	0	0	0	0	0	58.00
60.00 06000	LABORATORY	0	40,256	60,525	100,781	1,344	60.00
65.00 06500	RESPIRATORY THERAPY	0	6,966	10,473	17,439	434	65.00
66.00 06600	PHYSICAL THERAPY	0	54,215	81,513	135,728	723	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	0	418	67.00
68.00 06800	SPEECH PATHOLOGY	0	0	0	0	202	68.00
69.00 06900	ELECTROCARDIOLOGY	0	4,964	7,463	12,427	254	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00 03950	OTHER ANCILLARY	0	0	0	0	0	76.00
76.01 03951	SLEEP LAB	0	4,946	7,436	12,382	43	76.01
76.03 03953	WOUND CARE	0	0	0	0	85	76.03
OUTPATIENT SERVICE COST CENTERS							
90.00 09000	CLINIC	0	0	0	0	0	90.00
91.00 09100	EMERGENCY	0	41,850	62,922	104,772	1,220	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
95.00 09500	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	0	1,757,738	2,642,755	4,400,493	16,578	118.00
NONREIMBURSABLE COST CENTERS							
190.00 19000	GI FT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00 07950	OTHER NONREIMBURSABLE COST CENTER	0	0	0	0	0	194.00
194.01 07955	MARKETING	0	0	0	0	0	194.01
194.02 07952	SENIOR CIRCLE	0	0	0	0	0	194.02
194.03 07953	BUSINESS HEALTH	0	0	0	0	0	194.03
194.04 07954	VACANT SPACE	0	0	0	0	0	194.04
200.00	Cross Foot Adjustments					0	200.00
201.00	Negative Cost Centers					0	201.00
202.00	TOTAL (sum lines 118 through 201)	0	1,757,738	2,642,755	4,400,493	16,578	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0075

Period:
From 10/01/2021
To 09/30/2022Worksheet B
Part II
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Cost Center Description	COMMUNITIES	ADMITTING	CASHIERING/ACCOUNTS RECEIVABLE	OTHER	OPERATION OF PLANT			
				ADMINISTRATIVE AND GENERAL				
				5.01	5.02	5.03	5.04	7.00
GENERAL SERVICE COST CENTERS								
1. 00 00100	CAP REL COSTS-BLDG & FIXT							1. 00
2. 00 00200	CAP REL COSTS-MVBL EQUIP							2. 00
4. 00 00400	EMPLOYEE BENEFITS DEPARTMENT							4. 00
5. 01 01160	COMMUNITIES	10, 287						5. 01
5. 02 00540	ADMITTING	172	19, 574					5. 02
5. 03 00550	CASHIERING/ACCOUNTS RECEIVABLE	125	428	26, 474				5. 03
5. 04 00560	OTHER ADMINISTRATIVE AND GENERAL	812	3, 271	4, 531	452, 353			5. 04
7. 00 00700	OPERATION OF PLANT	187	2, 071	2, 862	59, 001	1, 694, 954		7. 00
8. 00 00800	LAUNDRY & LINEN SERVICE	16	62	86	1, 778	0		8. 00
9. 00 00900	HOUSEKEEPING	31	292	404	8, 329	15, 812		9. 00
10. 00 01000	DIETARY	140	172	237	4, 893	89, 881		10. 00
11. 00 01100	CAFETERIA	0	430	594	12, 253	0		11. 00
13. 00 01300	NURSING ADMINISTRATION	47	651	899	18, 539	16, 323		13. 00
14. 00 01400	CENTRAL SERVICES & SUPPLY	78	284	393	8, 096	65, 345		14. 00
15. 00 01500	PHARMACY	172	501	692	14, 269	27, 808		15. 00
16. 00 01600	MEDICAL RECORDS & LIBRARY	390	370	512	10, 555	106, 596		16. 00
17. 00 01700	SOCIAL SERVICE	0	166	229	4, 725	2, 897		17. 00
INPATIENT ROUTINE SERVICE COST CENTERS								
30. 00 03000	ADULTS & PEDIATRICS	312	2, 283	3, 155	65, 034	622, 827		30. 00
31. 00 03100	INTENSIVE CARE UNIT	78	290	401	8, 264	36, 992		31. 00
43. 00 04300	NURSERY	16	357	493	10, 163	0		43. 00
44. 00 04400	SKILLED NURSING FACILITY	0	0	0	0	0		44. 00
ANCILLARY SERVICE COST CENTERS								
50. 00 05000	OPERATING ROOM	531	1, 792	2, 476	51, 048	227, 556		50. 00
51. 00 05100	RECOVERY ROOM	0	0	0	0	0		51. 00
52. 00 05200	DELIVERY ROOM & LABOR ROOM	31	283	391	8, 057	0		52. 00
53. 00 05300	ANESTHESIOLOGY	0	0	0	0	0		53. 00
54. 00 05400	RADIOLOGY-DIAGNOSTIC	328	968	1, 338	27, 570	184, 958		54. 00
54. 01 03630	ULTRA SOUND	0	0	0	0	0		54. 01
56. 00 05600	RADIOISOTOPES	31	76	105	2, 171	9, 797		56. 00
57. 00 05700	CT SCAN	0	0	0	0	0		57. 00
58. 00 05800	MRI	0	0	0	0	0		58. 00
60. 00 06000	LABORATORY	297	1, 357	1, 876	38, 677	75, 721		60. 00
65. 00 06500	RESPIRATORY THERAPY	47	255	353	7, 274	13, 103		65. 00
66. 00 06600	PHYSICAL THERAPY	78	468	647	13, 338	101, 978		66. 00
67. 00 06700	OCCUPATIONAL THERAPY	0	221	306	6, 309	0		67. 00
68. 00 06800	SPEECH PATHOLOGY	0	107	148	3, 052	0		68. 00
69. 00 06900	ELECTROCARDIOLOGY	94	150	207	4, 261	9, 337		69. 00
71. 00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	56	77	1, 591	0		71. 00
72. 00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	138	191	3, 944	0		72. 00
73. 00 07300	DRUGS CHARGED TO PATIENTS	0	623	862	17, 765	0		73. 00
76. 00 03950	OTHER ANCILLARY	0	0	0	0	0		76. 00
76. 01 03951	SLEEP LAB	0	35	48	995	9, 303		76. 01
76. 03 03953	WOUND CARE	0	50	70	1, 437	0		76. 03
OUTPATIENT SERVICE COST CENTERS								
90. 00 09000	CLINIC	0	0	0	0	0		90. 00
91. 00 09100	EMERGENCY		265	1, 231	1, 702	35, 078	78, 720	91. 00
92. 00 09200	OBSERVATION BEDS (NON-DISTINCT PART)							92. 00
OTHER REIMBURSABLE COST CENTERS								
95. 00 09500	AMBULANCE SERVICES	0	0	0	0	0		95. 00
SPECIAL PURPOSE COST CENTERS								
118. 00	Subtotals (sum of lines 1 through 117)	4, 278	19, 438	26, 285	448, 466	1, 694, 954	118. 00	
NONREIMBURSABLE COST CENTERS								
190. 00 19000	GI FT, FLOWER, COFFEE SHOP & CANTEEN	62	1	2	40	0		190. 00
192. 00 19200	PHYSICIANS' PRIVATE OFFICES	5, 947	135	187	3, 847	0		192. 00
194. 00 07950	OTHER NONREIMBURSABLE COST CENTER	0	0	0	0	0		194. 00
194. 01 07955	MARKETING	0	0	0	0	0		194. 01
194. 02 07952	SENIOR CITCLE	0	0	0	0	0		194. 02
194. 03 07953	BUSINESS HEALTH	0	0	0	0	0		194. 03
194. 04 07954	VACANT SPACE	0	0	0	0	0		194. 04
200. 00	Cross Foot Adjustments							200. 00
201. 00	Negative Cost Centers	0	0	0	0	0		201. 00
202. 00	TOTAL (sum lines 118 through 201)	10, 287	19, 574	26, 474	452, 353	1, 694, 954	202. 00	

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0075

Period:
From 10/01/2021
To 09/30/2022Worksheet B
Part II
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Cost Center Description	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	13.00	1.00
							8.00
GENERAL SERVICE COST CENTERS							
1.00 00100	CAP REL COSTS-BLDG & FIXT						2.00
2.00 00200	CAP REL COSTS-MVBL EQUIP						4.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT						5.01
5.01 01160	COMMUNITIES						5.02
5.02 00540	ADMITTING						5.03
5.03 00550	CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.04 00560	OTHER ADMINISTRATIVE AND GENERAL						7.00
7.00 00700	OPERATION OF PLANT						8.00
8.00 00800	LAUNDRY & LINEN SERVICE	1, 942					9.00
9.00 00900	HOUSEKEEPING	0	46, 348				10.00
10.00 01000	DIETARY	0	2, 481	217, 431			11.00
11.00 01100	CAFETERIA	0	0	0	13, 278		13.00
13.00 01300	NURSING ADMINISTRATION	0	451	0	550	60, 345	14.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	1, 804	0	355		15.00
15.00 01500	PHARMACY	0	768	0	562		16.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	2, 942	0	340		17.00
17.00 01700	SOCIAL SERVICE	0	80	0	234		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000	ADULTS & PEDIATRICS	767	17, 190	217, 431	2, 316	28, 483	30.00
31.00 03100	INTENSIVE CARE UNIT	1	1, 021	0	158	1, 863	31.00
43.00 04300	NURSERY	0	0	0	338	0	43.00
44.00 04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00 05000	OPERATING ROOM	353	6, 281	0	1, 532	15, 266	50.00
51.00 05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	0	267	0	52.00
53.00 05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	252	5, 105	0	1, 476	128	54.00
54.01 03630	ULTRA SOUND	0	0	0	0	0	54.01
56.00 05600	RADIOISOTOPES	0	270	0	72	0	56.00
57.00 05700	CT SCAN	0	0	0	0	0	57.00
58.00 05800	MRI	0	0	0	0	0	58.00
60.00 06000	LABORATORY	0	2, 090	0	1, 817	0	60.00
65.00 06500	RESPIRATORY THERAPY	17	362	0	417	0	65.00
66.00 06600	PHYSICAL THERAPY	4	2, 815	0	776	0	66.00
67.00 06700	OCCUPATIONAL THERAPY	36	0	0	464	0	67.00
68.00 06800	SPEECH PATHOLOGY	0	0	0	178	0	68.00
69.00 06900	ELECTROCARDIOLOGY	0	258	0	268	2, 329	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00 03950	OTHER ANCILLARY	0	0	0	0	0	76.00
76.01 03951	SLEEP LAB	0	257	0	36	0	76.01
76.03 03953	WOUND CARE	63	0	0	99	794	76.03
OUTPATIENT SERVICE COST CENTERS							
90.00 09000	CLINIC	0	0	0	0	0	90.00
91.00 09100	EMERGENCY	449	2, 173	0	1, 023	11, 482	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS							
95.00 09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	1, 942	46, 348	217, 431	13, 278	60, 345	118.00
NONREIMBURSABLE COST CENTERS							
190.00 19000	GI FT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00 07950	OTHER NONREIMBURSABLE COST CENTER	0	0	0	0	0	194.00
194.01 07955	MARKETING	0	0	0	0	0	194.01
194.02 07952	SENIOR CIRCLE	0	0	0	0	0	194.02
194.03 07953	BUSINESS HEALTH	0	0	0	0	0	194.03
194.04 07954	VACANT SPACE	0	0	0	0	0	194.04
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	1, 942	46, 348	217, 431	13, 278	60, 345	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0075

Period:
From 10/01/2021
To 09/30/2022Worksheet B
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Cost Center Description	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal					
					14.00	15.00	16.00	17.00	24.00	
GENERAL SERVICE COST CENTERS										
1.00 00100	CAP REL COSTS-BLDG & FIXT									1.00
2.00 00200	CAP REL COSTS-MVBL EQUIP									2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT									4.00
5.01 01160	COMMUNICATIONS									5.01
5.02 00540	ADMITTING									5.02
5.03 00550	CASHIERING/ACCOUNTS RECEIVABLE									5.03
5.04 00560	OTHER ADMINISTRATIVE AND GENERAL									5.04
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	163,545								14.00
15.00 01500	PHARMACY	6,433	88,995							15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	37	0	263,864						16.00
17.00 01700	SOCIAL SERVICE	73	0	0	12,505					17.00
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00 03000	ADULTS & PEDIATRICS	11,724	0	16,938	10,742	1,830,630				30.00
31.00 03100	INTENSIVE CARE UNIT	71	0	719	324	99,611				31.00
43.00 04300	NURSERY	0	0	1,119	1,439	14,326				43.00
44.00 04400	SKILLED NURSING FACILITY	0	0	0	0	0				44.00
ANCILLARY SERVICE COST CENTERS										
50.00 05000	OPERATING ROOM	50,983	0	41,824	0	704,213				50.00
51.00 05100	RECOVERY ROOM	0	0	0	0	0				51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	886	0	10,233				52.00
53.00 05300	ANESTHESIOLOGY	0	0	0	0	0				53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	6,545	0	50,508	0	526,791				54.00
54.01 03630	ULTRA SOUND	0	0	0	0	0				54.01
56.00 05600	RADIOISOTOPES	3,611	0	1,633	0	30,867				56.00
57.00 05700	CT SCAN	0	0	0	0	0				57.00
58.00 05800	MRI	0	0	0	0	0				58.00
60.00 06000	LABORATORY	37,747	0	57,347	0	319,054				60.00
65.00 06500	RESPIRATORY THERAPY	2,199	0	4,235	0	46,135				65.00
66.00 06600	PHYSICAL THERAPY	992	0	5,523	0	263,070				66.00
67.00 06700	OCCUPATIONAL THERAPY	225	0	4,458	0	12,437				67.00
68.00 06800	SPEECH PATHOLOGY	64	0	1,518	0	5,269				68.00
69.00 06900	ELECTROCARDIOLOGY	250	0	9,399	0	39,234				69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	14,227	0	13,705	0	29,656				71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	20,912	0	4,499	0	29,684				72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	88,995	20,164	0	128,409				73.00
76.00 03950	OTHER ANCILLARY	0	0	0	0	0				76.00
76.01 03951	SLEEP LAB	292	0	524	0	23,915				76.01
76.03 03953	WOUND CARE	699	0	490	0	3,787				76.03
OUTPATIENT SERVICE COST CENTERS										
90.00 09000	CLINIC	0	0	255	0	255				90.00
91.00 09100	EMERGENCY	6,461	0	28,120	0	272,696				91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART									92.00
OTHER REIMBURSABLE COST CENTERS										
95.00 09500	AMBULANCE SERVICES	0	0	0	0	0				95.00
SPECIAL PURPOSE COST CENTERS										
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	163,545	88,995	263,864	12,505	4,390,272				118.00
NONREIMBURSABLE COST CENTERS										
190.00 19000	GI FT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	105				190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	10,116				192.00
194.00 07950	OTHER NONREIMBURSABLE COST CENTER	0	0	0	0	0				194.00
194.01 07955	MARKETING	0	0	0	0	0				194.01
194.02 07952	SENIOR CITCLE	0	0	0	0	0				194.02
194.03 07953	BUSINESS HEALTH	0	0	0	0	0				194.03
194.04 07954	VACANT SPACE	0	0	0	0	0				194.04
200.00	Cross Foot Adjustments									200.00
201.00	Negative Cost Centers	0	0	0	0	0				201.00
202.00	TOTAL (sum lines 118 through 201)	163,545	88,995	263,864	12,505	4,400,493				202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0075

Period:
From 10/01/2021
To 09/30/2022Worksheet B
Part II
Date/Time Prepared:
2/28/2023 8:13 pm

Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
GENERAL SERVICE COST CENTERS				
1.00 00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00 00200	CAP REL COSTS-MVBL EQUIP			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.01 01160	COMMUNITI ONS			5.01
5.02 00540	ADMITTING			5.02
5.03 00550	CASHIERING/ACCOUNTS RECEIVABLE			5.03
5.04 00560	OTHER ADMISTRATIVE AND GENERAL			5.04
7.00 00700	OPERATION OF PLANT			7.00
8.00 00800	LAUNDRY & LINEN SERVICE			8.00
9.00 00900	HOUSEKEEPING			9.00
10.00 01000	DIETARY			10.00
11.00 01100	CAFETERIA			11.00
13.00 01300	NURSING ADMINISTRATION			13.00
14.00 01400	CENTRAL SERVICES & SUPPLY			14.00
15.00 01500	PHARMACY			15.00
16.00 01600	MEDICAL RECORDS & LIBRARY			16.00
17.00 01700	SOCIAL SERVICE			17.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00 03000	ADULTS & PEDIATRICS	0	1,830,630	30.00
31.00 03100	INTENSIVE CARE UNIT	0	99,611	31.00
43.00 04300	NURSERY	0	14,326	43.00
44.00 04400	SKILLED NURSING FACILITY	0	0	44.00
ANCILLARY SERVICE COST CENTERS				
50.00 05000	OPERATING ROOM	0	704,213	50.00
51.00 05100	RECOVERY ROOM	0	0	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	10,233	52.00
53.00 05300	ANESTHESIOLOGY	0	0	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	526,791	54.00
54.01 03630	ULTRA SOUND	0	0	54.01
56.00 05600	RADIOISOTOPE	0	30,867	56.00
57.00 05700	CT SCAN	0	0	57.00
58.00 05800	MRI	0	0	58.00
60.00 06000	LABORATORY	0	319,054	60.00
65.00 06500	RESPIRATORY THERAPY	0	46,135	65.00
66.00 06600	PHYSICAL THERAPY	0	263,070	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	12,437	67.00
68.00 06800	SPEECH PATHOLOGY	0	5,269	68.00
69.00 06900	ELECTROCARDIOLOGY	0	39,234	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	29,656	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	29,684	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	128,409	73.00
76.00 03950	OTHER ANCILLARY	0	0	76.00
76.01 03951	SLEEP LAB	0	23,915	76.01
76.03 03953	WOUND CARE	0	3,787	76.03
OUTPATIENT SERVICE COST CENTERS				
90.00 09000	CLINIC	0	255	90.00
91.00 09100	EMERGENCY	0	272,696	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		92.00
OTHER REIMBURSABLE COST CENTERS				
95.00 09500	AMBULANCE SERVICES	0	0	95.00
SPECIAL PURPOSE COST CENTERS				
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	0	4,390,272	118.00
NONREIMBURSABLE COST CENTERS				
190.00 19000	GI FT, FLOWER, COFFEE SHOP & CANTEEN	0	105	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	10,116	192.00
194.00 07950	OTHER NONREIMBURSABLE COST CENTER	0	0	194.00
194.01 07955	MARKETING	0	0	194.01
194.02 07952	SENIOR CITCLE	0	0	194.02
194.03 07953	BUSINESS HEALTH	0	0	194.03
194.04 07954	VACANT SPACE	0	0	194.04
200.00	Cross Foot Adjustments	0	0	200.00
201.00	Negative Cost Centers	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	0	4,400,493	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0075

Period:
From 10/01/2021
To 09/30/2022

Worksheet B-1

Date/Time Prepared:
2/28/2023 8:13 pm

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	COMMUNITIES (NONPATIENT PHONES)	Reconciliation		
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)					
	1.00	2.00	4.00	5.01	5A.02		
GENERAL SERVICE COST CENTERS							
1.00 00100	CAP REL COSTS-BLDG & FIXT	194,042				1.00	
2.00 00200	CAP REL COSTS-MVBLE EQUIP		194,042			2.00	
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	731	731	12,397,889		4.00	
5.01 01160	COMMUNITIES	448	448	95,250	659	5.01	
5.02 00540	ADMITTING	827	827	484,794	11	-730,519	
5.03 00550	CASHIERING/ACCOUNTS RECEIVABLE	1,143	1,143	0	8	5.03	
5.04 00560	OTHER ADMINISTRATIVE AND GENERAL	19,523	19,523	745,024	52	5.04	
7.00 00700	OPERATION OF PLANT	71,895	71,895	294,217	12	7.00	
8.00 00800	LAUNDRY & LINEN SERVICE	0	0	0	1	8.00	
9.00 00900	HOUSEKEEPING	928	928	325,374	2	9.00	
10.00 01000	DIETARY	5,275	5,275	193	9	10.00	
11.00 01100	CAFETERIA	0	0	761	0	11.00	
13.00 01300	NURSING ADMINISTRATION	958	958	867,449	3	13.00	
14.00 01400	CENTRAL SERVICES & SUPPLY	3,835	3,835	163,588	5	14.00	
15.00 01500	PHARMACY	1,632	1,632	582,668	11	15.00	
16.00 01600	MEDICAL RECORDS & LIBRARY	6,256	6,256	185,734	25	16.00	
17.00 01700	SOCIAL SERVICE	170	170	183,872	0	17.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000	ADULTS & PEDIATRICS	36,553	36,553	1,850,192	20	30.00	
31.00 03100	INTENSIVE CARE UNIT	2,171	2,171	145,971	5	31.00	
43.00 04300	NURSERY	0	0	300,121	1	43.00	
44.00 04400	SKILLED NURSING FACILITY	0	0	0	0	44.00	
ANCILLARY SERVICE COST CENTERS							
50.00 05000	OPERATING ROOM	13,355	13,355	1,275,887	34	50.00	
51.00 05100	RECOVERY ROOM	0	0	0	0	51.00	
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	237,584	2	52.00	
53.00 05300	ANESTHESIOLOGY	0	0	0	0	53.00	
54.00 05400	RADIOLOGY-DIAGNOSTIC	10,855	10,855	1,080,934	21	54.00	
54.01 03630	ULTRA SOUND	0	0	0	0	54.01	
56.00 05600	RADIOISOTOPES	575	575	45,595	2	56.00	
57.00 05700	CT SCAN	0	0	0	0	57.00	
58.00 05800	MRI	0	0	0	0	58.00	
60.00 06000	LABORATORY	4,444	4,444	1,005,271	19	60.00	
65.00 06500	RESPIRATORY THERAPY	769	769	324,876	3	65.00	
66.00 06600	PHYSICAL THERAPY	5,985	5,985	540,403	5	66.00	
67.00 06700	OCCUPATIONAL THERAPY	0	0	312,892	0	67.00	
68.00 06800	SPEECH PATHOLOGY	0	0	151,110	0	68.00	
69.00 06900	ELECTROCARDIOLOGY	548	548	189,775	6	69.00	
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00	
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00	
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00	
76.00 03950	OTHER ANCILLARY	0	0	0	0	76.00	
76.01 03951	SLEEP LAB	546	546	32,391	0	76.01	
76.03 03953	WOUND CARE	0	0	63,740	0	76.03	
OUTPATIENT SERVICE COST CENTERS							
90.00 09000	CLINIC	0	0	0	0	90.00	
91.00 09100	EMERGENCY		4,620	4,620	912,223	17	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS							
95.00 09500	AMBULANCE SERVICES	0	0	0	0	95.00	
SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	194,042	194,042	12,397,889	274	-730,519	
NONREIMBURSABLE COST CENTERS							
190.00 19000	GI FT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	4	190.00	
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	381	192.00	
194.00 07950	OTHER NONREIMBURSABLE COST CENTER	0	0	0	0	194.00	
194.01 07955	MARKETING	0	0	0	0	194.01	
194.02 07952	SENIOR CITCLE	0	0	0	0	194.02	
194.03 07953	BUSINESS HEALTH	0	0	0	0	194.03	
194.04 07954	VACANT SPACE	0	0	0	0	194.04	
200.00	Cross Foot Adjustments					200.00	
201.00	Negative Cost Centers					201.00	
202.00	Cost to be allocated (per Wkst. B, Part I)	1,757,738	2,642,755	2,745,224	426,872	202.00	
203.00	Unit cost multiplier (Wkst. B, Part I)	9.058544	13.619500	0.221427	647,757208	203.00	
204.00	Cost to be allocated (per Wkst. B, Part II)			16,578	10,287	204.00	

Cost Center Description		CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	COMMUNITIES (NONPATIENT PHONES)	Reconciliation
		BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)			
		1.00	2.00			
205.00	Unit cost multiplier (Wkst. B, Part III)			0.001337	15.610015	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: 15-0075

Period:
From 10/01/2021
To 09/30/2022

Worksheet B-1

Cost Center Description		ADMITTING (ACCUM. COST)	Reconciliation	CASHIERING/ACCOUNTS RECEIVABLE (ACCUM. COST)	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	Date/Time Prepared: 2/28/2023 8:13 pm
		5.02	5A.03	5.03	5A.04	5.04	
GENERAL SERVICE COST CENTERS							
1. 00	00100 CAP REL COSTS-BLDG & FIXT						1. 00
2. 00	00200 CAP REL COSTS-MVBL EQUIP						2. 00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 01	01160 COMMUNICATIONS						5. 01
5. 02	00540 ADMITTING	35, 772, 269					5. 02
5. 03	00550 CASHIERING/ACCOUNTS RECEIVABLE	783, 148	-799, 141	35, 703, 647			5. 03
5. 04	00560 OTHER ADMINISTRATIVE AND GENERAL	5, 966, 197	0	6, 088, 045	-6, 224, 300	30, 278, 488	5. 04
7. 00	00700 OPERATION OF PLANT	3, 785, 441	0	3, 862, 743	0	3, 949, 203	7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	114, 083	0	116, 413	0	119, 019	8. 00
9. 00	00900 HOUSEKEEPING	534, 395	0	545, 308	0	557, 514	9. 00
10. 00	01000 DIETARY	313, 933	0	320, 344	0	327, 514	10. 00
11. 00	01100 CAFETERIA	786, 152	0	802, 206	0	820, 162	11. 00
13. 00	01300 NURSING ADMINISTRATION	1, 189, 458	0	1, 213, 748	0	1, 240, 915	13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	519, 447	0	530, 055	0	541, 919	14. 00
15. 00	01500 PHARMACY	915, 470	0	934, 165	0	955, 074	15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	677, 199	0	691, 028	0	706, 495	16. 00
17. 00	01700 SOCIAL SERVICE	303, 149	0	309, 340	0	316, 264	17. 00
INPATIENT ROUTINE SERVICE COST CENTERS							
30. 00	03000 ADULTS & PEDIATRICS	4, 172, 894	0	4, 258, 109	0	4, 353, 418	30. 00
31. 00	03100 INTENSIVE CARE UNIT	530, 237	0	541, 065	0	553, 176	31. 00
43. 00	04300 NURSERY	652, 040	0	665, 355	0	680, 248	43. 00
44. 00	04400 SKILLED NURSING FACILITY	0	0	0	0	0	44. 00
ANCILLARY SERVICE COST CENTERS							
50. 00	05000 OPERATING ROOM	3, 275, 165	0	3, 342, 047	0	3, 416, 852	50. 00
51. 00	05100 RECOVERY ROOM	0	0	0	0	0	51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	516, 955	0	527, 512	0	539, 319	52. 00
53. 00	05300 ANESTHESIOLOGY	0	0	0	0	0	53. 00
54. 00	05400 RADIOLGY-DIAGNOSTIC	1, 768, 874	0	1, 804, 996	0	1, 845, 397	54. 00
54. 01	03630 ULTRA SOUND	0	0	0	0	0	54. 01
56. 00	05600 RADIOTISOTEPE	139, 316	0	142, 161	0	145, 343	56. 00
57. 00	05700 CT SCAN	0	0	0	0	0	57. 00
58. 00	05800 MRI	0	0	0	0	0	58. 00
60. 00	06000 LABORATORY	2, 481, 469	0	2, 532, 143	0	2, 588, 820	60. 00
65. 00	06500 RESPIRATORY THERAPY	466, 663	0	476, 193	0	486, 852	65. 00
66. 00	06600 PHYSICAL THERAPY	855, 772	0	873, 248	0	892, 794	66. 00
67. 00	06700 OCCUPATIONAL THERAPY	404, 764	0	413, 030	0	422, 275	67. 00
68. 00	06800 SPEECH PATHOLOGY	195, 831	0	199, 830	0	204, 303	68. 00
69. 00	06900 ELECTROCARDIOLOGY	273, 389	0	278, 972	0	285, 216	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	102, 062	0	104, 146	0	106, 477	71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	253, 023	0	258, 190	0	263, 969	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	1, 139, 765	0	1, 163, 040	0	1, 189, 072	73. 00
76. 00	03950 OTHER ANCILLARY	0	0	0	0	0	76. 00
76. 01	03951 SLEEP LAB	63, 822	0	65, 125	0	66, 583	76. 01
76. 03	03953 WOUND CARE	92, 221	0	94, 104	0	96, 210	76. 03
OUTPATIENT SERVICE COST CENTERS							
90. 00	09000 CLINIC	0	0	0	0	0	90. 00
91. 00	09100 EMERGENCY	2, 250, 550	0	2, 296, 508	0	2, 347, 911	91. 00
92. 00	09200 OBSERVATION BEDS (NON-DI STINCT PART)						92. 00
OTHER REIMBURSABLE COST CENTERS							
95. 00	09500 AMBULANCE SERVICES	0	0	0	0	0	95. 00
SPECIAL PURPOSE COST CENTERS							
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	35, 522, 884	-799, 141	35, 449, 169	-6, 224, 300	30, 018, 314	118. 00
NONREIMBURSABLE COST CENTERS							
190. 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	2, 591	0	2, 644	0	2, 703	190. 00
192. 00	19200 PHYSICIANS' PRIVATE OFFICES	246, 794	0	251, 834	0	257, 471	192. 00
194. 00	07950 OTHER NONREIMBURSABLE COST CENTER	0	0	0	0	0	194. 00
194. 01	07955 MARKETING	0	0	0	0	0	194. 01
194. 02	07952 SENIOR CITCLE	0	0	0	0	0	194. 02
194. 03	07953 BUSINESS HEALTH	0	0	0	0	0	194. 03
194. 04	07954 VACANT SPACE	0	0	0	0	0	194. 04
200. 00	Cross Foot Adjustments						200. 00
201. 00	Negative Cost Centers						201. 00
202. 00	Cost to be allocated (per Wkst. B, Part I)	730, 519		799, 141		6, 224, 300	202. 00
203. 00	Unit cost multiplier (Wkst. B, Part I)	0. 020421		0. 022383		0. 205568	203. 00
204. 00	Cost to be allocated (per Wkst. B, Part II)	19, 574		26, 474		452, 353	204. 00
205. 00	Unit cost multiplier (Wkst. B, Part II)	0. 000547		0. 000741		0. 014940	205. 00
206. 00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0075

Period:
From 10/01/2021
To 09/30/2022Worksheet B-1
Date/Time Prepared:
2/28/2023 8:13 pm

Cost Center Description	ADMITTING (ACCUM. COST)	Reconciliation	CASHIERING/ACCO	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)
			OUNTS RECEIVABLE (ACCUM. COST)		
207.00 NAHE unit cost multiplier (Wkst. D, Parts III and IV)		5A.03	5.03	5A.04	5.04
					207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0075

Period:

From 10/01/2021
To 09/30/2022

Worksheet B-1

Date/Time Prepared:
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Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTES)	
GENERAL SERVICE COST CENTERS						
1. 00 00100	CAP REL COSTS-BLDG & FIXT					1. 00
2. 00 00200	CAP REL COSTS-MVBL EQUIP					2. 00
4. 00 00400	EMPLOYEE BENEFITS DEPARTMENT					4. 00
5. 01 01160	COMMUNICATIONS					5. 01
5. 02 00540	ADMINISTRATING					5. 02
5. 03 00550	CASHIERING/ACCOUNTS RECEIVABLE					5. 03
5. 04 00560	OTHER ADMINISTRATIVE AND GENERAL					5. 04
7. 00 00700	OPERATION OF PLANT	99,475				7. 00
8. 00 00800	LAUNDRY & LINEN SERVICE	0	167,428			8. 00
9. 00 00900	HOUSEKEEPING	928	0	98,547		9. 00
10. 00 01000	DIETARY	5,275	0	5,275	21,473	10. 00
11. 00 01100	CAFETERIA	0	0	0	0	13,167
13. 00 01300	NURSING ADMINISTRATION	958	0	958	0	545
14. 00 01400	CENTRAL SERVICES & SUPPLY	3,835	0	3,835	0	352
15. 00 01500	PHARMACY	1,632	0	1,632	0	557
16. 00 01600	MEDICAL RECORDS & LIBRARY	6,256	0	6,256	0	337
17. 00 01700	SOCIAL SERVICE	170	0	170	0	232
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000	ADULTS & PEDIATRICS	36,553	66,172	36,553	21,473	2,296
31. 00 03100	INTENSIVE CARE UNIT	2,171	93	2,171	0	157
43. 00 04300	NURSERY	0	0	0	0	335
44. 00 04400	SKILLED NURSING FACILITY	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS						
50. 00 05000	OPERATING ROOM	13,355	30,429	13,355	0	1,519
51. 00 05100	RECOVERY ROOM	0	0	0	0	0
52. 00 05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	265
53. 00 05300	ANESTHESIOLOGY	0	0	0	0	0
54. 00 05400	RADIOLOGY-DIAGNOSTIC	10,855	21,685	10,855	0	1,464
54. 01 03630	ULTRA SOUND	0	0	0	0	0
56. 00 05600	RADIOISOTYPE	575	0	575	0	71
57. 00 05700	CT SCAN	0	0	0	0	0
58. 00 05800	MRI	0	0	0	0	0
60. 00 06000	LABORATORY	4,444	0	4,444	0	1,802
65. 00 06500	RESPIRATORY THERAPY	769	1,502	769	0	414
66. 00 06600	PHYSICAL THERAPY	5,985	351	5,985	0	770
67. 00 06700	OCCUPATIONAL THERAPY	0	3,081	0	0	460
68. 00 06800	SPEECH PATHOLOGY	0	0	0	0	177
69. 00 06900	ELECTROCARDIOLOGY	548	0	548	0	266
71. 00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0
72. 00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73. 00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
76. 00 03950	OTHER ANCILLARY	0	0	0	0	0
76. 01 03951	SLEEP LAB	546	0	546	0	36
76. 03 03953	WOUND CARE	0	5,416	0	0	98
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000	CLINIC	0	0	0	0	0
91. 00 09100	EMERGENCY	4,620	38,699	4,620	0	1,014
92. 00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					92. 00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500	AMBULANCE SERVICES	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS						
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	99,475	167,428	98,547	21,473	13,167
NONREIMBURSABLE COST CENTERS						118. 00
190. 00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
192. 00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
194. 00 07950	OTHER NONREIMBURSABLE COST CENTER	0	0	0	0	0
194. 01 07955	MARKETING	0	0	0	0	0
194. 02 07952	SENIOR CITCLE	0	0	0	0	0
194. 03 07953	BUSINESS HEALTH	0	0	0	0	0
194. 04 07954	VACANT SPACE	0	0	0	0	0
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)	4,761,033	143,485	716,537	685,665	988,761
203. 00	Unit cost multiplier (Wkst. B, Part I)	47.861603	0.856995	7.271018	31.931495	75.093871
204. 00	Cost to be allocated (per Wkst. B, Part II)	1,694,954	1,942	46,348	217,431	13,278
205. 00	Unit cost multiplier (Wkst. B, Part II)	17.038995	0.011599	0.470314	10.125786	1.008430
206. 00	NAHE adjustment amount to be allocated (per Wkst. B-2)					206. 00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0075

Period:
From 10/01/2021
To 09/30/2022Worksheet B-1
Date/Time Prepared:
2/28/2023 8:13 pm

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

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0075

Period:
From 10/01/2021
To 09/30/2022

Worksheet B-1

Date/Time Prepared:
2/28/2023 8:13 pm

Cost Center Description		NURSING ADMINISTRATION (FTES IN NURSING ARE)	CENTRAL SERVICES & SUPPLY (COSTED REQUI S.)	PHARMACY (% COSTED EQUI)	MEDICAL RECORDS & LIBRARY (GROSS CHAR GES)	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-MVBL EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01160 COMMUNITIES						5.01
5.02	00540 ADMITTING						5.02
5.03	00550 CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.04	00560 OTHER ADMINISTRATIVE AND GENERAL						5.04
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	4,814,448					13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	2,014,378				14.00
15.00	01500 PHARMACY	0	79,231	1,139,765			15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	456	0	214,242,533		16.00
17.00	01700 SOCIAL SERVICE	0	904	0	0	3,710	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	2,272,355	144,405	0	13,748,712	3,187	30.00
31.00	03100 INTENSIVE CARE UNIT	148,617	877	0	583,721	96	31.00
43.00	04300 NURSERY	0	0	0	908,235	427	43.00
44.00	04400 SKILLED NURSING FACILITY	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	1,217,942	627,959	0	33,948,158	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	718,982	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLGY-DIAGNOSTIC	10,242	80,615	0	40,997,127	0	54.00
54.01	03630 ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600 RADIOTISOTEPE	0	44,473	0	1,325,435	0	56.00
57.00	05700 CT SCAN	0	0	0	0	0	57.00
58.00	05800 MRI	0	0	0	0	0	58.00
60.00	06000 LABORATORY	0	464,928	0	46,614,141	0	60.00
65.00	06500 RESPIRATORY THERAPY	0	27,085	0	3,437,894	0	65.00
66.00	06600 PHYSICAL THERAPY	0	12,213	0	4,483,303	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	2,774	0	3,618,463	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	789	0	1,232,053	0	68.00
69.00	06900 ELECTROCARDIOLOGY	185,851	3,082	0	7,629,206	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	175,232	0	11,124,181	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	257,568	0	3,652,057	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	1,139,765	16,366,700	0	73.00
76.00	03950 OTHER ANCILLARY	0	0	0	0	0	76.00
76.01	03951 SLEEP LAB	0	3,599	0	425,096	0	76.01
76.03	03953 WOUND CARE	63,369	8,613	0	397,397	0	76.03
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	0	0	207,094	0	90.00
91.00	09100 EMERGENCY	916,072	79,575	0	22,824,578	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES	0	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	4,814,448	2,014,378	1,139,765	214,242,533	3,710	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950 OTHER NONREIMBURSABLE COST CENTER	0	0	0	0	0	194.00
194.01	07955 MARKETING	0	0	0	0	0	194.01
194.02	07952 SENIOR CITI RCLE	0	0	0	0	0	194.02
194.03	07953 BUSINESS HEALTH	0	0	0	0	0	194.03
194.04	07954 VACANT SPACE	0	0	0	0	0	194.04
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	1,589,750	891,186	1,318,263	1,222,146	408,472	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0.330204	0.442412	1.156609	0.005704	110,100270	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	60,345	163,545	88,995	263,864	12,505	204.00
205.00	Unit cost multiplier (Wkst. B, Part III)	0.012534	0.081189	0.078082	0.001232	3,370620	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0075

Period:
From 10/01/2021
To 09/30/2022Worksheet B-1
Date/Time Prepared:
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Cost Center Description	NURSING ADMINISTRATION (FTES IN NURSING ARE)	CENTRAL SERVICES & SUPPLY (COSTED REQUI S.)	PHARMACY (% COSTED R EQUI)	MEDICAL RECORDS & LIBRARY (GROSS CHAR GES)	SOCIAL SERVICE (TOTAL PATIENT DAYS)	
	13.00	14.00	15.00	16.00	17.00	206.00
206.00 NAHE adjustment amount to be allocated (per Wkst. B-2) 207.00 NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0075

Period:
From 10/01/2021
To 09/30/2022Worksheet C
Part I
Date/Time Prepared:
2/28/2023 8:13 pm

Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Title XVIII		Hospital Costs		
			Total Costs	RCE Disallowance			
			1.00	2.00	3.00	4.00	5.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000	ADULTS & PEDIATRICS	9,421,947		0	9,421,947	30.00	
31.00 03100	INTENSIVE CARE UNIT	861,816		0	861,816	31.00	
43.00 04300	NURSERY	897,435		0	897,435	43.00	
44.00 04400	SKILLED NURSING FACILITY	0		0	0	44.00	
ANCILLARY SERVICE COST CENTERS							
50.00 05000	OPERATING ROOM	5,869,315		0	5,869,315	50.00	
51.00 05100	RECOVERY ROOM	0		0	0	51.00	
52.00 05200	DELIVERY ROOM & LABOR ROOM	674,187		0	674,187	52.00	
53.00 05300	ANESTHESIOLOGY	0		0	0	53.00	
54.00 05400	RADIOLOGY-DIAGNOSTIC	3,224,633		0	3,224,633	54.00	
54.01 03630	ULTRA SOUND	0		0	0	54.01	
56.00 05600	RADIOISOTYPE	239,489		0	239,489	56.00	
57.00 05700	CT SCAN	0		0	0	57.00	
58.00 05800	MRI	0		0	0	58.00	
60.00 06000	LABORATORY	3,973,009		0	3,973,009	60.00	
65.00 06500	RESPIRATORY THERAPY	693,299	0	0	693,299	65.00	
66.00 06600	PHYSICAL THERAPY	1,495,392	0	0	1,495,392	66.00	
67.00 06700	OCCUPATIONAL THERAPY	568,131	0	0	568,131	67.00	
68.00 06800	SPEECH PATHOLOGY	266,970	0	0	266,970	68.00	
69.00 06900	ELECTROCARDIOLOGY	500,285		0	500,285	69.00	
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	269,342		0	269,342	71.00	
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	453,015		0	453,015	72.00	
73.00 07300	DRUGS CHARGED TO PATIENTS	2,845,126		0	2,845,126	73.00	
76.00 03950	OTHER ANCILLARY	0		0	0	76.00	
76.01 03951	SLEEP LAB	117,092		0	117,092	76.01	
76.03 03953	WOUND CARE	154,990		0	154,990	76.03	
OUTPATIENT SERVICE COST CENTERS							
90.00 09000	CLINIC	1,181		0	1,181	90.00	
91.00 09100	EMERGENCY	3,662,476		0	3,662,476	91.00	
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,446,451		0	1,446,451	92.00	
OTHER REIMBURSABLE COST CENTERS							
95.00 09500	AMBULANCE SERVICES	0		0	0	95.00	
200.00	Subtotal (see instructions)	37,635,581	0	37,635,581	0	200.00	
201.00	Less Observation Beds	1,446,451		1,446,451	1,446,451	201.00	
202.00	Total (see instructions)	36,189,130	0	36,189,130	0	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0075

Period:
From 10/01/2021
To 09/30/2022Worksheet C
Part I
Date/Time Prepared:
2/28/2023 8:13 pm

Cost Center Description	Title XVIII			Hospital	PPS
	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio
	Inpatient	Outpatient	Total (col. 6 + col. 7)		
	6.00	7.00	8.00	9.00	10.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00 03000	ADULTS & PEDIATRICS	11,672,470		11,672,470	
31.00 03100	INTENSIVE CARE UNIT	583,721		583,721	
43.00 04300	NURSERY	908,235		908,235	
44.00 04400	SKILLED NURSING FACILITY	0		0	
ANCILLARY SERVICE COST CENTERS					
50.00 05000	OPERATING ROOM	6,903,217	27,044,941	33,948,158	0.172891
51.00 05100	RECOVERY ROOM	0	0	0	0.000000
52.00 05200	DELIVERY ROOM & LABOR ROOM	707,345	11,637	718,982	0.937697
53.00 05300	ANESTHESIOLOGY	0	0	0	0.000000
54.00 05400	RADIOLOGY-DIAGNOSTIC	4,302,459	36,694,668	40,997,127	0.078655
54.01 03630	ULTRA SOUND	0	0	0	0.000000
56.00 05600	RADIOISOTOPES	60,162	1,265,273	1,325,435	0.180687
57.00 05700	CT SCAN	0	0	0	0.000000
58.00 05800	MRI	0	0	0	0.000000
60.00 06000	LABORATORY	7,514,827	39,099,314	46,614,141	0.085232
65.00 06500	RESPIRATORY THERAPY	3,109,536	328,358	3,437,894	0.201664
66.00 06600	PHYSICAL THERAPY	1,453,820	3,029,483	4,483,303	0.333547
67.00 06700	OCCUPATIONAL THERAPY	1,025,445	2,593,018	3,618,463	0.157009
68.00 06800	SPEECH PATHOLOGY	84,395	1,147,658	1,232,053	0.216687
69.00 06900	ELECTROCARDIOLOGY	1,019,934	6,609,272	7,629,206	0.065575
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,768,605	6,355,576	11,124,181	0.024212
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	517,979	3,134,078	3,652,057	0.124044
73.00 07300	DRUGS CHARGED TO PATIENTS	4,984,204	11,382,496	16,366,700	0.173836
76.00 03950	OTHER ANCILLARY	0	0	0	0.000000
76.01 03951	SLEEP LAB	9,326	415,770	425,096	0.275448
76.03 03953	WOUND CARE	13,121	384,276	397,397	0.390013
OUTPATIENT SERVICE COST CENTERS					
90.00 09000	CLINIC	46,431	160,663	207,094	0.005703
91.00 09100	EMERGENCY	2,926,121	19,898,457	22,824,578	0.160462
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	363,483	1,712,759	2,076,242	0.696668
OTHER REIMBURSABLE COST CENTERS					
95.00 09500	AMBULANCE SERVICES	0	0	0	0.000000
200.00	Subtotal (see instructions)	52,974,836	161,267,697	214,242,533	
201.00	Less Observation Beds				
202.00	Total (see instructions)	52,974,836	161,267,697	214,242,533	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0075

Worksheet C

Part I

Date/Time Prepared:

2/28/2023 8:13 pm

Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	PPS
		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
44.00	04400 SKILLED NURSING FACILITY				44.00
	ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.172891			50.00
51.00	05100 RECOVERY ROOM	0.000000			51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.937697			52.00
53.00	05300 ANESTHESIOLOGY	0.000000			53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.078655			54.00
54.01	03630 ULTRA SOUND	0.000000			54.01
56.00	05600 RADIOISOTOPE	0.180687			56.00
57.00	05700 CT SCAN	0.000000			57.00
58.00	05800 MRI	0.000000			58.00
60.00	06000 LABORATORY	0.085232			60.00
65.00	06500 RESPIRATORY THERAPY	0.201664			65.00
66.00	06600 PHYSICAL THERAPY	0.333547			66.00
67.00	06700 OCCUPATIONAL THERAPY	0.157009			67.00
68.00	06800 SPEECH PATHOLOGY	0.216687			68.00
69.00	06900 ELECTROCARDIOLOGY	0.065575			69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.024212			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.124044			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.173836			73.00
76.00	03950 OTHER ANCILLARY	0.000000			76.00
76.01	03951 SLEEP LAB	0.275448			76.01
76.03	03953 WOUND CARE	0.390013			76.03
	OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0.005703			90.00
91.00	09100 EMERGENCY	0.160462			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.696668			92.00
	OTHER REIMBURSABLE COST CENTERS				
95.00	09500 AMBULANCE SERVICES	0.000000			95.00
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: 15-0075

Period:
From 10/01/2021
To 09/30/2022Worksheet C
Part I
Date/Time Prepared:
2/28/2023 8:13 pm

Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Title XIX		Hospital Costs			
			Total Costs	RCE Disallowance				
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00 03000	ADULTS & PEDIATRICS	9,421,947			9,421,947	0	9,421,947	30.00
31.00 03100	INTENSIVE CARE UNIT	861,816			861,816	0	861,816	31.00
43.00 04300	NURSERY	897,435			897,435	0	897,435	43.00
44.00 04400	SKILLED NURSING FACILITY	0			0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00 05000	OPERATING ROOM	5,869,315			5,869,315	0	5,869,315	50.00
51.00 05100	RECOVERY ROOM	0			0	0	0	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	674,187			674,187	0	674,187	52.00
53.00 05300	ANESTHESIOLOGY	0			0	0	0	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	3,224,633			3,224,633	0	3,224,633	54.00
54.01 03630	ULTRA SOUND	0			0	0	0	54.01
56.00 05600	RADIOISOTOPE	239,489			239,489	0	239,489	56.00
57.00 05700	CT SCAN	0			0	0	0	57.00
58.00 05800	MRI	0			0	0	0	58.00
60.00 06000	LABORATORY	3,973,009			3,973,009	0	3,973,009	60.00
65.00 06500	RESPIRATORY THERAPY	693,299			693,299	0	693,299	65.00
66.00 06600	PHYSICAL THERAPY	1,495,392			1,495,392	0	1,495,392	66.00
67.00 06700	OCCUPATIONAL THERAPY	568,131			568,131	0	568,131	67.00
68.00 06800	SPEECH PATHOLOGY	266,970			266,970	0	266,970	68.00
69.00 06900	ELECTROCARDIOLOGY	500,285			500,285	0	500,285	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	269,342			269,342	0	269,342	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	453,015			453,015	0	453,015	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	2,845,126			2,845,126	0	2,845,126	73.00
76.00 03950	OTHER ANCILLARY	0			0	0	0	76.00
76.01 03951	SLEEP LAB	117,092			117,092	0	117,092	76.01
76.03 03953	WOUND CARE	154,990			154,990	0	154,990	76.03
OUTPATIENT SERVICE COST CENTERS								
90.00 09000	CLINIC	1,181			1,181	0	1,181	90.00
91.00 09100	EMERGENCY	3,662,476			3,662,476	0	3,662,476	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,446,451			1,446,451	0	1,446,451	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00 09500	AMBULANCE SERVICES	0			0	0	0	95.00
200.00	Subtotal (see instructions)	37,635,581			37,635,581	0	37,635,581	200.00
201.00	Less Observation Beds	1,446,451			1,446,451	0	1,446,451	201.00
202.00	Total (see instructions)	36,189,130			36,189,130	0	36,189,130	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0075

Period:

From 10/01/2021

To 09/30/2022

Worksheet C

Part I

Date/Time Prepared:

2/28/2023 8:13 pm

Cost Center Description	Title XIX			Hospital	Cost
	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio
	Inpatient	Outpatient	Total (col. 6 + col. 7)		
	6.00	7.00	8.00	9.00	10.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00 03000	ADULTS & PEDIATRICS	11,672,470		11,672,470	
31.00 03100	INTENSIVE CARE UNIT	583,721		583,721	
43.00 04300	NURSERY	908,235		908,235	
44.00 04400	SKILLED NURSING FACILITY	0		0	
ANCILLARY SERVICE COST CENTERS					
50.00 05000	OPERATING ROOM	6,903,217	27,044,941	33,948,158	0.172891
51.00 05100	RECOVERY ROOM	0	0	0	0.000000
52.00 05200	DELIVERY ROOM & LABOR ROOM	707,345	11,637	718,982	0.937697
53.00 05300	ANESTHESIOLOGY	0	0	0	0.000000
54.00 05400	RADIOLOGY-DIAGNOSTIC	4,302,459	36,694,668	40,997,127	0.078655
54.01 03630	ULTRA SOUND	0	0	0	0.000000
56.00 05600	RADIOISOTOPES	60,162	1,265,273	1,325,435	0.180687
57.00 05700	CT SCAN	0	0	0	0.000000
58.00 05800	MRI	0	0	0	0.000000
60.00 06000	LABORATORY	7,514,827	39,099,314	46,614,141	0.085232
65.00 06500	RESPIRATORY THERAPY	3,109,536	328,358	3,437,894	0.201664
66.00 06600	PHYSICAL THERAPY	1,453,820	3,029,483	4,483,303	0.333547
67.00 06700	OCCUPATIONAL THERAPY	1,025,445	2,593,018	3,618,463	0.157009
68.00 06800	SPEECH PATHOLOGY	84,395	1,147,658	1,232,053	0.216687
69.00 06900	ELECTROCARDIOLOGY	1,019,934	6,609,272	7,629,206	0.065575
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,768,605	6,355,576	11,124,181	0.024212
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	517,979	3,134,078	3,652,057	0.124044
73.00 07300	DRUGS CHARGED TO PATIENTS	4,984,204	11,382,496	16,366,700	0.173836
76.00 03950	OTHER ANCILLARY	0	0	0	0.000000
76.01 03951	SLEEP LAB	9,326	415,770	425,096	0.275448
76.03 03953	WOUND CARE	13,121	384,276	397,397	0.390013
OUTPATIENT SERVICE COST CENTERS					
90.00 09000	CLINIC	46,431	160,663	207,094	0.005703
91.00 09100	EMERGENCY	2,926,121	19,898,457	22,824,578	0.160462
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	363,483	1,712,759	2,076,242	0.696668
OTHER REIMBURSABLE COST CENTERS					
95.00 09500	AMBULANCE SERVICES	0	0	0	0.000000
200.00	Subtotal (see instructions)	52,974,836	161,267,697	214,242,533	
201.00	Less Observation Beds				
202.00	Total (see instructions)	52,974,836	161,267,697	214,242,533	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0075

Worksheet C

Period:
From 10/01/2021
To 09/30/2022Part I
Date/Time Prepared:
2/28/2023 8:13 pm

Cost Center Description	PPS Inpatient Ratio	Title XIX	Hospital	Cost
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
44.00 04400	SKILLED NURSING FACILITY			44.00
ANCILLARY SERVICE COST CENTERS				
50.00 05000	OPERATING ROOM	0.000000		50.00
51.00 05100	RECOVERY ROOM	0.000000		51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00 05300	ANESTHESIOLOGY	0.000000		53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
54.01 03630	ULTRA SOUND	0.000000		54.01
56.00 05600	RADIOSCOPE	0.000000		56.00
57.00 05700	CT SCAN	0.000000		57.00
58.00 05800	MRI	0.000000		58.00
60.00 06000	LABORATORY	0.000000		60.00
65.00 06500	RESPIRATORY THERAPY	0.000000		65.00
66.00 06600	PHYSICAL THERAPY	0.000000		66.00
67.00 06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00 06800	SPEECH PATHOLOGY	0.000000		68.00
69.00 06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00 03950	OTHER ANCILLARY	0.000000		76.00
76.01 03951	SLEEP LAB	0.000000		76.01
76.03 03953	WOUND CARE	0.000000		76.03
OUTPATIENT SERVICE COST CENTERS				
90.00 09000	CLINIC	0.000000		90.00
91.00 09100	EMERGENCY	0.000000		91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
OTHER REIMBURSABLE COST CENTERS				
95.00 09500	AMBULANCE SERVICES	0.000000		95.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 15-0075

Period:
From 10/01/2021
To 09/30/2022Worksheet D
Part I
Date/Time Prepared:
2/28/2023 8:13 pm

		Title XVIII		Hospital	PPS	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)
		1.00	2.00	3.00	4.00	5.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,830,630	0	1,830,630	3,765	486.22
31.00	INTENSIVE CARE UNIT	99,611		99,611	96	1,037.61
43.00	NURSERY	14,326		14,326	427	33.55
44.00	SKILLED NURSING FACILITY	0		0	0	0.00
200.00	Total (Lines 30 through 199)	1,944,567		1,944,567	4,288	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	843	409,883			30.00
31.00	INTENSIVE CARE UNIT	32	33,204			31.00
43.00	NURSERY	0	0			43.00
44.00	SKILLED NURSING FACILITY	0	0			44.00
200.00	Total (Lines 30 through 199)	875	443,087			200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 15-0075

Period:
From 10/01/2021
To 09/30/2022Worksheet D
Part II
Date/Time Prepared:
2/28/2023 8:13 pm

Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Title XVIII		Hospital	Capital Costs (column 3 x column 4)	PPS
		Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges		
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	704,213	33,948,158	0.020744	713,547	14,802
51.00 05100	RECOVERY ROOM	0	0	0.000000	0	0
52.00 05200	DELIVERY ROOM & LABOR ROOM	10,233	718,982	0.014233	0	0
53.00 05300	ANESTHESIOLOGY	0	0	0.000000	0	0
54.00 05400	RADIOLOGY-DIAGNOSTIC	526,791	40,997,127	0.012849	1,259,903	16,188
54.01 03630	ULTRA SOUND	0	0	0.000000	0	0
56.00 05600	RADIOISOTOPE	30,867	1,325,435	0.023288	18,203	424
57.00 05700	CT SCAN	0	0	0.000000	0	0
58.00 05800	MRI	0	0	0.000000	0	0
60.00 06000	LABORATORY	319,054	46,614,141	0.006845	1,748,669	11,970
65.00 06500	RESPIRATORY THERAPY	46,135	3,437,894	0.013420	834,197	11,195
66.00 06600	PHYSICAL THERAPY	263,070	4,483,303	0.058678	186,194	10,925
67.00 06700	OCCUPATIONAL THERAPY	12,437	3,618,463	0.003437	114,546	394
68.00 06800	SPEECH PATHOLOGY	5,269	1,232,053	0.004277	15,626	67
69.00 06900	ELECTROCARDIOLOGY	39,234	7,629,206	0.005143	338,385	1,740
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	29,656	11,124,181	0.002666	764,991	2,039
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	29,684	3,652,057	0.008128	150,427	1,223
73.00 07300	DRUGS CHARGED TO PATIENTS	128,409	16,366,700	0.007846	923,686	7,247
76.00 03950	OTHER ANCILLARY	0	0	0.000000	0	0
76.01 03951	SLEEP LAB	23,915	425,096	0.056258	0	0
76.03 03953	WOUND CARE	3,787	397,397	0.009530	0	0
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	255	207,094	0.001231	0	0
91.00 09100	EMERGENCY	272,696	22,824,578	0.011947	913,686	10,916
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	281,037	2,076,242	0.135358	130,724	17,695
OTHER REIMBURSABLE COST CENTERS						
95.00 09500	AMBULANCE SERVICES					95.00
200.00	Total (Lines 50 through 199)	2,726,742	201,078,107		8,112,784	200.00
					106,825	

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0075

Period:

From 10/01/2021

To 09/30/2022

Worksheet D

Part III

Date/Time Prepared:

2/28/2023 8:13 pm

Cost Center Description		Title XVIII		Hospital		PPS
		Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health Cost	
		1A	1.00	2A	2.00	3.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	0	0	0	0	0
31.00	03100 INTENSIVE CARE UNIT	0	0	0	0	0
43.00	04300 NURSERY	0	0	0	0	0
44.00	04400 SKILLED NURSING FACILITY	0	0	0	0	0
200.00	Total (Lines 30 through 199)	0	0	0	0	0
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	3,765	0.00	843
31.00	03100 INTENSIVE CARE UNIT	0	0	96	0.00	32
43.00	04300 NURSERY	0	0	427	0.00	0
44.00	04400 SKILLED NURSING FACILITY	0	0	0	0.00	0
200.00	Total (Lines 30 through 199)	0	0	4,288		875
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
44.00	04400 SKILLED NURSING FACILITY	0				44.00
200.00	Total (Lines 30 through 199)	0				200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 15-0075

Period:
From 10/01/2021
To 09/30/2022Worksheet D
Part IV
Date/Time Prepared:
2/28/2023 8:13 pm

Cost Center Description	Non Physician Anesthetist Cost	Title XVIII		Hospital		Allied Health
		Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	3A	
ANCILLARY SERVICE COST CENTERS						
1.00	2A	2.00	3A	3.00		
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
53.00 05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01 03630 ULTRA SOUND	0	0	0	0	0	54.01
56.00 05600 RADIOISOTOPE	0	0	0	0	0	56.00
57.00 05700 CT SCAN	0	0	0	0	0	57.00
58.00 05800 MRI	0	0	0	0	0	58.00
60.00 06000 LABORATORY	0	0	0	0	0	60.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00 03950 OTHER ANCILLARY	0	0	0	0	0	76.00
76.01 03951 SLEEP LAB	0	0	0	0	0	76.01
76.03 03953 WOUND CARE	0	0	0	0	0	76.03
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	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500 AMBULANCE SERVICES						95.00
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: 15-0075

Period:
From 10/01/2021
To 09/30/2022Worksheet D
Part IV
Date/Time Prepared:
2/28/2023 8:13 pm

Cost Center Description	All Other Medical Education Cost	Title XVIII		Hospital		Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	PPS
		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)	6.00		
	4.00	5.00			8.00		
ANCILLARY SERVICE COST CENTERS							
50.00 05000	OPERATING ROOM	0	0	0	33,948,158	0.000000	50.00
51.00 05100	RECOVERY ROOM	0	0	0	0	0.000000	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	0	718,982	0.000000	52.00
53.00 05300	ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	0	0	40,997,127	0.000000	54.00
54.01 03630	ULTRA SOUND	0	0	0	0	0.000000	54.01
56.00 05600	RADIOISOTOPE	0	0	0	1,325,435	0.000000	56.00
57.00 05700	CT SCAN	0	0	0	0	0.000000	57.00
58.00 05800	MRI	0	0	0	0	0.000000	58.00
60.00 06000	LABORATORY	0	0	0	46,614,141	0.000000	60.00
65.00 06500	RESPIRATORY THERAPY	0	0	0	3,437,894	0.000000	65.00
66.00 06600	PHYSICAL THERAPY	0	0	0	4,483,303	0.000000	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	3,618,463	0.000000	67.00
68.00 06800	SPEECH PATHOLOGY	0	0	0	1,232,053	0.000000	68.00
69.00 06900	ELECTROCARDIOLOGY	0	0	0	7,629,206	0.000000	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	11,124,181	0.000000	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	3,652,057	0.000000	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	16,366,700	0.000000	73.00
76.00 03950	OTHER ANCILLARY	0	0	0	0	0.000000	76.00
76.01 03951	SLEEP LAB	0	0	0	425,096	0.000000	76.01
76.03 03953	WOUND CARE	0	0	0	397,397	0.000000	76.03
OUTPATIENT SERVICE COST CENTERS							
90.00 09000	CLINIC	0	0	0	207,094	0.000000	90.00
91.00 09100	EMERGENCY	0	0	0	22,824,578	0.000000	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	2,076,242	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00 09500	AMBULANCE SERVICES	0	0	0	201,078,107		95.00
200.00	Total (Lines 50 through 199)	0	0	0			200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0075

Period:
From 10/01/2021
To 09/30/2022Worksheet D
Part IV
Date/Time Prepared:
2/28/2023 8:13 pm

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)	PPS	Title XVIII Hospital			
							9.00	10.00	11.00	12.00
ANCILLARY SERVICE COST CENTERS										
50.00 05000	OPERATING ROOM	0.000000	713,547	0	5,528,326	0	50.00			
51.00 05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00			
52.00 05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00			
53.00 05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00			
54.00 05400	RADIOLOGY-DIAGNOSTIC	0.000000	1,259,903	0	6,958,282	0	54.00			
54.01 03630	ULTRA SOUND	0.000000	0	0	0	0	54.01			
56.00 05600	RADIOISOTOPE	0.000000	18,203	0	324,037	0	56.00			
57.00 05700	CT SCAN	0.000000	0	0	0	0	57.00			
58.00 05800	MRI	0.000000	0	0	0	0	58.00			
60.00 06000	LABORATORY	0.000000	1,748,669	0	2,455,507	0	60.00			
65.00 06500	RESPIRATORY THERAPY	0.000000	834,197	0	71,482	0	65.00			
66.00 06600	PHYSICAL THERAPY	0.000000	186,194	0	4,922	0	66.00			
67.00 06700	OCCUPATIONAL THERAPY	0.000000	114,546	0	861	0	67.00			
68.00 06800	SPEECH PATHOLOGY	0.000000	15,626	0	0	0	68.00			
69.00 06900	ELECTROCARDIOLOGY	0.000000	338,385	0	1,959,780	0	69.00			
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	764,991	0	606,606	0	71.00			
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	150,427	0	757,693	0	72.00			
73.00 07300	DRUGS CHARGED TO PATIENTS	0.000000	923,686	0	4,843,963	0	73.00			
76.00 03950	OTHER ANCILLARY	0.000000	0	0	0	0	76.00			
76.01 03951	SLEEP LAB	0.000000	0	0	57,791	0	76.01			
76.03 03953	WOUND CARE	0.000000	0	0	194,861	0	76.03			
OUTPATIENT SERVICE COST CENTERS										
90.00 09000	CLINIC	0.000000	0	0	39,907	0	90.00			
91.00 09100	EMERGENCY	0.000000	913,686	0	2,614,403	0	91.00			
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	130,724	0	275,658	0	92.00			
OTHER REIMBURSABLE COST CENTERS										
95.00 09500	AMBULANCE SERVICES						95.00			
200.00	Total (Lines 50 through 199)		8,112,784	0	26,694,079	0	200.00			

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-0075

Period:
From 10/01/2021
To 09/30/2022Worksheet D
Part V
Date/Time Prepared:
2/28/2023 8:13 pm

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Title XVIII		Hospital		PPS Costs (see inst.)
		PPS Reimbursed Services (see inst.)	Charges	Cost Reimbursed Services Subj ect To Ded. & Coi ns. (see inst.)	Cost Reimbursed Services Not Subj ect To Ded. & Coi ns. (see inst.)	
		1. 00	2. 00	3. 00	4. 00	5. 00
ANCILLARY SERVICE COST CENTERS						
50. 00 05000	OPERATING ROOM	0. 172891	5, 528, 326	0	0	955, 798
51. 00 05100	RECOVERY ROOM	0. 000000	0	0	0	51. 00
52. 00 05200	DELIVERY ROOM & LABOR ROOM	0. 937697	0	0	0	52. 00
53. 00 05300	ANESTHESIOLOGY	0. 000000	0	0	0	53. 00
54. 00 05400	RADIOLOGY-DIAGNOSTIC	0. 078655	6, 958, 282	0	0	547, 304
54. 01 03630	ULTRA SOUND	0. 000000	0	0	0	54. 01
56. 00 05600	RADIOISOTOPE	0. 180687	324, 037	0	0	58, 549
57. 00 05700	CT SCAN	0. 000000	0	0	0	57. 00
58. 00 05800	MRI	0. 000000	0	0	0	58. 00
60. 00 06000	LABORATORY	0. 085232	2, 455, 507	4, 293	0	209, 288
65. 00 06500	RESPIRATORY THERAPY	0. 201664	71, 482	0	0	14, 415
66. 00 06600	PHYSICAL THERAPY	0. 333547	4, 922	0	0	1, 642
67. 00 06700	OCCUPATIONAL THERAPY	0. 157009	861	0	0	135
68. 00 06800	SPEECH PATHOLOGY	0. 216687	0	0	0	68. 00
69. 00 06900	ELECTROCARDIOLOGY	0. 065575	1, 959, 780	0	0	128, 513
71. 00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0. 024212	606, 606	0	0	14, 687
72. 00 07200	IMPL. DEV. CHARGED TO PATIENTS	0. 124044	757, 693	0	0	93, 987
73. 00 07300	DRUGS CHARGED TO PATIENTS	0. 173836	4, 843, 963	0	16, 220	842, 055
76. 00 03950	OTHER ANCILLARY	0. 000000	0	0	0	76. 00
76. 01 03951	SLEEP LAB	0. 275448	57, 791	0	0	15, 918
76. 03 03953	WOUND CARE	0. 390013	194, 861	0	0	75, 998
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000	CLINIC	0. 005703	39, 907	0	0	228
91. 00 09100	EMERGENCY	0. 160462	2, 614, 403	0	0	419, 512
92. 00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0. 696668	275, 658	0	0	192, 042
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500	AMBULANCE SERVICES	0. 000000	26, 694, 079	4, 293	16, 220	3, 570, 071
200. 00	Subtotal (see instructions)					95. 00 200. 00
201. 00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	201. 00
202. 00	Net Charges (line 200 - line 201)		26, 694, 079	4, 293	16, 220	3, 570, 071 202. 00

Cost Center Description	Costs		Title XVIII	Hospital	PPS
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
	6.00	7.00			
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM	0	0			50.00
51.00 05100 RECOVERY ROOM	0	0			51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0			52.00
53.00 05300 ANESTHESIOLOGY	0	0			53.00
54.00 05400 RADIOL OGY-DIAGNOSTIC	0	0			54.00
54.01 03630 ULTRA SOUND	0	0			54.01
56.00 05600 RADIOTR OPE	0	0			56.00
57.00 05700 CT SCAN	0	0			57.00
58.00 05800 MRI	0	0			58.00
60.00 06000 LABORATORY	366	0			60.00
65.00 06500 RESPIRATORY THERAPY	0	0			65.00
66.00 06600 PHYSICAL THERAPY	0	0			66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0			67.00
68.00 06800 SPEECH PATHOLOGY	0	0			68.00
69.00 06900 ELECTROCARDIOLOGY	0	0			69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0			71.00
72.00 07200 MPL. DEV. CHARGED TO PATIENTS	0	0			72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	2,820			73.00
76.00 03950 OTHER ANCILLARY	0	0			76.00
76.01 03951 SLEEP LAB	0	0			76.01
76.03 03953 WOUND CARE	0	0			76.03
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
OTHER REIMBURSABLE COST CENTERS					
95.00 09500 AMBULANCE SERVICES	0				95.00
200.00 Subtotal (see instructions)	366	2,820			200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0				201.00
202.00 Net Charges (Line 200 - Line 201)	366	2,820			202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-0075

Period:
From 10/01/2021
To 09/30/2022Worksheet D
Part V
Date/Time Prepared:
2/28/2023 8:13 pm

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Title XIX		Hospital	Cost
		Charges PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coi ns. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coi ns. (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. 172891	0	0	189, 240
51. 00 05100	RECOVERY ROOM	0. 000000	0	0	0
52. 00 05200	DELIVERY ROOM & LABOR ROOM	0. 937697	0	0	0
53. 00 05300	ANESTHESIOLOGY	0. 000000	0	0	0
54. 00 05400	RADIOLOGY-DIAGNOSTIC	0. 078655	0	0	393, 770
54. 01 03630	ULTRA SOUND	0. 000000	0	0	0
56. 00 05600	RADIOISOTOPE	0. 180687	0	0	15, 414
57. 00 05700	CT SCAN	0. 000000	0	0	0
58. 00 05800	MRI	0. 000000	0	0	0
60. 00 06000	LABORATORY	0. 085232	0	0	389, 994
65. 00 06500	RESPIRATORY THERAPY	0. 201664	0	0	6, 635
66. 00 06600	PHYSICAL THERAPY	0. 333547	0	0	286, 907
67. 00 06700	OCCUPATIONAL THERAPY	0. 157009	0	0	492, 081
68. 00 06800	SPEECH PATHOLOGY	0. 216687	0	0	184, 210
69. 00 06900	ELECTROCARDIOLOGY	0. 065575	0	0	27, 529
71. 00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0. 024212	0	0	20, 817
72. 00 07200	IMPL. DEV. CHARGED TO PATIENTS	0. 124044	0	0	42, 354
73. 00 07300	DRUGS CHARGED TO PATIENTS	0. 173836	0	0	58, 813
76. 00 03950	OTHER ANCILLARY	0. 000000	0	0	0
76. 01 03951	SLEEP LAB	0. 275448	0	0	0
76. 03 03953	WOUND CARE	0. 390013	0	0	2, 570
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000	CLINIC	0. 005703	0	0	1, 835
91. 00 09100	EMERGENCY	0. 160462	0	0	432, 950
92. 00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0. 696668	0	0	65, 120
OTHER REIMBURSABLE COST CENTERS					
95. 00 09500	AMBULANCE SERVICES	0. 000000	0	0	95. 00
200. 00	Subtotal (see instructions)		0	0	2, 610, 239
201. 00	Less PBP Clinic Lab. Services-Program Only Charges			0	0
202. 00	Net Charges (Line 200 - Line 201)		0	0	2, 610, 239
					0202. 00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-0075

Period:

From 10/01/2021

To 09/30/2022

Worksheet D

Part V

Date/Time Prepared:

2/28/2023 8:13 pm

Cost Center Description	Costs		Title XIX	Hospital	Cost
	Cost Reimbursed	Cost Reimbursed			
	Services Subject To Ded. & Coi ns. (see inst.)	Services Not Subject To Ded. & Coi ns. (see inst.)			
	6.00	7.00			
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM	0	32,718			50.00
51.00 05100 RECOVERY ROOM	0	0			51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0			52.00
53.00 05300 ANESTHESIOLOGY	0	0			53.00
54.00 05400 RADIOL OGY-DIAGNOSTIC	0	30,972			54.00
54.01 03630 ULTRA SOUND	0	0			54.01
56.00 05600 RADI OISOTOPE	0	2,785			56.00
57.00 05700 CT SCAN	0	0			57.00
58.00 05800 MRI	0	0			58.00
60.00 06000 LABORATORY	0	33,240			60.00
65.00 06500 RESPIRATORY THERAPY	0	1,338			65.00
66.00 06600 PHYSICAL THERAPY	0	95,697			66.00
67.00 06700 OCCUPATIONAL THERAPY	0	77,261			67.00
68.00 06800 SPEECH PATHOLOGY	0	39,916			68.00
69.00 06900 ELECTROCARDIOLOGY	0	1,805			69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	504			71.00
72.00 07200 MPL. DEV. CHARGED TO PATIENTS	0	5,254			72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	10,224			73.00
76.00 03950 OTHER ANCILLARY	0	0			76.00
76.01 03951 SLEEP LAB	0	0			76.01
76.03 03953 WOUND CARE	0	1,002			76.03
OUTPATIENT SERVICE COST CENTERS					
90.00 09000 CLINIC	0	10			90.00
91.00 09100 EMERGENCY	0	69,472			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	45,367			92.00
OTHER REIMBURSABLE COST CENTERS					
95.00 09500 AMBULANCE SERVICES	0				95.00
200.00 Subtotal (see instructions)	0	447,565			200.00
201.00 Less PBP Clinic Lab. Services-Program	0				201.00
Only Charges					
202.00 Net Charges (Line 200 - Line 201)	0	447,565			202.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0075

Period:
From 10/01/2021
To 09/30/2022Worksheet D-1
Date/Time Prepared:
2/28/2023 8:13 pm

	Title XVIII	Hospital	PPS
Cost Center Description			1.00
PART I - ALL PROVIDER COMPONENTS			
INPATIENT DAYS			
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	5,222	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,765	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	3,187	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)	1,457	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)	843	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)	888	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)	9,421,947	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)	9,421,947	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)	9,421,947	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY			
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS			
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	2,502.51	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,109,616	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	2,109,616	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0075

Period:
From 10/01/2021
To 09/30/2022Worksheet D-1
Date/Time Prepared:
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Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Title XVIII Hospital		PPS
						1.00	2.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	0	42.00
43.00	INTENSIVE CARE UNIT	861,816	96	8,977.25	32	287,272		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)						1,084,124	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48) (see instructions)						3,481,012	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)						443,087	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						106,825	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)						549,912	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						2,931,100	53.00
TARGET AMOUNT AND LIMIT COMPUTATION								
54.00	Program discharges						0	54.00
55.00	Target amount per discharge						0.00	55.00
56.00	Target amount (line 54 x line 55)						0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						0	57.00
58.00	Bonus payment (see instructions)						0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket						0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket						0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						0	61.00
62.00	Relief payment (see instructions)						0	62.00
63.00	Allowable inpatient cost plus incentive payment (see instructions)						0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST								
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)						0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)						0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH (see instructions)						0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY								
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00	
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00	
72.00	Program routine service cost (line 9 x line 71)						72.00	
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00	
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00	
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00	
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00	
77.00	Program capital-related costs (line 9 x line 76)						77.00	
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00	
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00	
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00	
81.00	Inpatient routine service cost per diem limitation						81.00	
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00	
83.00	Reasonable inpatient routine service costs (see instructions)						83.00	
84.00	Program inpatient ancillary services (see instructions)						84.00	
85.00	Utilization review - physician compensation (see instructions)						85.00	
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00	
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST								
87.00	Total observation bed days (see instructions)						578	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						2,502.51	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)						1,446,451	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0075

Period:
From 10/01/2021
To 09/30/2022Worksheet D-1
Date/Time Prepared:
2/28/2023 8:13 pm

Cost Center Description	Cost	Routine Cost (from line 21)	Title XVIII		Hospital Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	PPS
			Column 1 ÷ Column 2	Total Observation Bed Cost (from line 89)		
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00 Capital-related cost	1,830,630	9,421,947	0.194294	1,446,451	281,037	90.00
91.00 Nursing Program cost	0	9,421,947	0.000000	1,446,451	0	91.00
92.00 Allied health cost	0	9,421,947	0.000000	1,446,451	0	92.00
93.00 All other Medical Education	0	9,421,947	0.000000	1,446,451	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-0075

Period:
From 10/01/2021
To 09/30/2022Worksheet D-3
Date/Time Prepared:
2/28/2023 8:13 pm

Cost Center Description	Title XVIII	Hospital		PPS
		Ratio of Cost To Charges	Inpatient Program Charges	
		1.00	2.00	
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00 03000	ADULTS & PEDIATRICS		2,303,335	30.00
31.00 03100	INTENSIVE CARE UNIT		185,109	31.00
43.00 04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS				
50.00 05000	OPERATING ROOM	0.172891	713,547	123,366
51.00 05100	RECOVERY ROOM	0.000000	0	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0.937697	0	52.00
53.00 05300	ANESTHESIOLOGY	0.000000	0	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0.078655	1,259,903	99,098
54.01 03630	ULTRA SOUND	0.000000	0	54.01
56.00 05600	RADIOISOTYPE	0.180687	18,203	3,289
57.00 05700	CT SCAN	0.000000	0	57.00
58.00 05800	MRI	0.000000	0	58.00
60.00 06000	LABORATORY	0.085232	1,748,669	149,043
65.00 06500	RESPIRATORY THERAPY	0.201664	834,197	168,228
66.00 06600	PHYSICAL THERAPY	0.333547	186,194	62,104
67.00 06700	OCCUPATIONAL THERAPY	0.157009	114,546	17,985
68.00 06800	SPEECH PATHOLOGY	0.216687	15,626	3,386
69.00 06900	ELECTROCARDIOLOGY	0.065575	338,385	22,190
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.024212	764,991	18,522
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0.124044	150,427	18,660
73.00 07300	DRUGS CHARGED TO PATIENTS	0.173836	923,686	160,570
76.00 03950	OTHER ANCILLARY	0.000000	0	76.00
76.01 03951	SLEEP LAB	0.275448	0	76.01
76.03 03953	WOUND CARE	0.390013	0	76.03
OUTPATIENT SERVICE COST CENTERS				
90.00 09000	CLINIC	0.005703	0	90.00
91.00 09100	EMERGENCY	0.160462	913,686	146,612
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.696668	130,724	91,071
OTHER REIMBURSABLE COST CENTERS				
95.00 09500	AMBULANCE SERVICES			95.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		8,112,784	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00	Net charges (line 200 minus line 201)		8,112,784	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-0075

Period:
From 10/01/2021
To 09/30/2022

Worksheet D-3

Component CCN: 15-U075

Date/Time Prepared:
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		Title XVIII	Swing Beds - SNF	PPS
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			
31.00	03100 INTENSIVE CARE UNIT			
43.00	04300 NURSERY			
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.172891	0	0
51.00	05100 RECOVERY ROOM	0.000000	0	0
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.937697	0	0
53.00	05300 ANESTHESIOLOGY	0.000000	0	0
54.00	05400 RADIOLGY-DIAGNOSTIC	0.078655	17, 958	1, 412
54.01	03630 ULTRA SOUND	0.000000	0	0
56.00	05600 RADIOTRISOTYPE	0.180687	0	0
57.00	05700 CT SCAN	0.000000	0	0
58.00	05800 MRI	0.000000	0	0
60.00	06000 LABORATORY	0.085232	160, 564	13, 685
65.00	06500 RESPIRATORY THERAPY	0.201664	429, 450	86, 605
66.00	06600 PHYSICAL THERAPY	0.333547	545, 551	181, 967
67.00	06700 OCCUPATIONAL THERAPY	0.157009	417, 036	65, 478
68.00	06800 SPEECH PATHOLOGY	0.216687	30, 343	6, 575
69.00	06900 ELECTROCARDIOLOGY	0.065575	5, 884	386
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.024212	278, 582	6, 745
72.00	07200 IMP. DEV. CHARGED TO PATIENTS	0.124044	0	0
73.00	07300 DRUGS CHARGED TO PATIENTS	0.173836	303, 061	52, 683
76.00	03950 OTHER ANCILLARY	0.000000	0	0
76.01	03951 SLEEP LAB	0.275448	0	0
76.03	03953 WOUND CARE	0.390013	1, 606	626
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0.005703	0	0
91.00	09100 EMERGENCY	0.160462	0	0
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.696668	0	0
OTHER REIMBURSABLE COST CENTERS				
95.00	09500 AMBULANCE SERVICES			
200.00	Total (sum of lines 50 through 94 and 96 through 98)		2, 190, 035	416, 162
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00	Net charges (line 200 minus line 201)		2, 190, 035	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-0075

Period:
From 10/01/2021
To 09/30/2022

Worksheet D-3

Date/Time Prepared:
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		Title XIX	Hospital	Cost
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
		1.00	2.00	3.00
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000 ADULTS & PEDIATRICS		124,149	30.00
31.00	03100 INTENSIVE CARE UNIT		5,878	31.00
43.00	04300 NURSERY		35,512	43.00
	ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATING ROOM	0.172891	148,446	25,665
51.00	05100 RECOVERY ROOM	0.000000	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.937697	14,653	13,740
53.00	05300 ANESTHESIOLOGY	0.000000	0	53.00
54.00	05400 RADIOLGY-DIAGNOSTIC	0.078655	24,514	1,928
54.01	03630 ULTRA SOUND	0.000000	0	54.01
56.00	05600 RADIOTRISOTOPES	0.180687	5,716	1,033
57.00	05700 CT SCAN	0.000000	0	57.00
58.00	05800 MRI	0.000000	0	58.00
60.00	06000 LABORATORY	0.085232	111,986	9,545
65.00	06500 RESPIRATORY THERAPY	0.201664	23,425	4,724
66.00	06600 PHYSICAL THERAPY	0.333547	6,198	2,067
67.00	06700 OCCUPATIONAL THERAPY	0.157009	944	148
68.00	06800 SPEECH PATHOLOGY	0.216687	361	78
69.00	06900 ELECTROCARDIOLOGY	0.065575	18,611	1,220
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.024212	75,449	1,827
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.124044	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.173836	48,539	8,438
76.00	03950 OTHER ANCILLARY	0.000000	0	76.00
76.01	03951 SLEEP LAB	0.275448	0	76.01
76.03	03953 WOUND CARE	0.390013	0	76.03
	OUTPATIENT SERVICE COST CENTERS			
90.00	09000 CLINIC	0.005703	1,113	6
91.00	09100 EMERGENCY	0.160462	44,361	7,118
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.696668	8,200	5,713
	OTHER REIMBURSABLE COST CENTERS			
95.00	09500 AMBULANCE SERVICES			95.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		532,516	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)		532,516	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 15-0075

Period:
From 10/01/2021
To 09/30/2022Worksheet E
Part A
Date/Time Prepared:
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	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)	0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	1,921,369	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)	20,399	2.04
3.00	Managed Care Simulated Payments	2,166,243	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	48.41	4.00
Indirect Medical Education Adjustment			
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions)	0.00	5.00
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)	0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.	0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.	0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)	0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)	0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.	0.00	11.00
12.00	Current year allowable FTE (see instructions)	0.00	12.00
13.00	Total allowable FTE count for the prior year.	0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.	0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.	0.00	15.00
16.00	Adjustment for residents in initial years of the program	0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure	0.00	17.00
18.00	Adjusted rolling average FTE count	0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)	0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.000000	21.00
22.00	IME payment adjustment (see instructions)	0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)	0	22.01
Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA			
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105(f)(1)(iv)(C).	0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)	0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)	0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)	0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)	0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)	0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)	0	28.01
29.00	Total IME payment (sum of lines 22 and 28)	0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	0	29.01
Disproportionate Share Adjustment			
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	2.23	30.00
31.00	Percentage of Medicaid patient days (see instructions)	23.91	31.00
32.00	Sum of lines 30 and 31	26.14	32.00
33.00	Allowable disproportionate share percentage (see instructions)	10.78	33.00
34.00	Disproportionate share adjustment (see instructions)	51,781	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 15-0075

Period:
From 10/01/2021
To 09/30/2022Worksheet E
Part A
Date/Time Prepared:
2/28/2023 8:13 pm

		Title XVIII	Hospital	PPS
		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	<u>Uncompensated Care Adjustment</u>			
35.00	Total uncompensated care amount (see instructions)	0	7,192,008,710	35.00
35.01	Factor 3 (see instructions)	0.000000000	0.000025414	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	0	182,778	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	0	182,778	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	182,778		36.00
	<u>Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)</u>			
40.00	Total Medicare discharges (see instructions)	0		40.00
		Before 1/1	On/After 1/1	
		1.00	1.01	
41.00	Total ESRD Medicare discharges (see instructions)	0	0	41.00
41.01	Total ESRD Medicare covered and paid discharges (see instructions)	0	0	41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days (see instructions)	0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00	0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00
47.00	Subtotal (see instructions)	2,176,327		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)		2,176,327	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		147,635	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		61,116	54.00
54.01	Islet isolation add-on payment		0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0	55.00
56.00	Cost of physicians' services in a teaching hospital (see instructions)		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)		2,385,078	59.00
60.00	Primary payer payments		4,603	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		2,380,475	61.00
62.00	Deductibles billed to program beneficiaries		315,856	62.00
63.00	Coinsurance billed to program beneficiaries		0	63.00
64.00	Allowable bad debts (see instructions)		15,395	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		10,007	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		8,007	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		2,074,626	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)		0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	70.00
70.50	Rural Community Hospital Demonstration Project (\$410A Demonstration) adjustment (see instructions)		0	70.50
70.87	Demonstration payment adjustment amount before sequestration		0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)		0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		0	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)		-14,472	70.94
70.95	Recovery of accelerated depreciation		0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 15-0075

Period:
From 10/01/2021
To 09/30/2022Worksheet E
Part A
Date/Time Prepared:
2/28/2023 8:13 pm

	Title XVIII	Hospital	PPS	
		FFY (yyyy)	Amount	
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)	2022	495,626	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)		2,555,780	71.00
71.01	Sequestration adjustment (see instructions)		19,168	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
71.03	Sequestration adjustment-PARHM pass-throughs		0	71.03
72.00	Interim payments		2,445,577	72.00
72.01	Interim payments-PARHM		0	72.01
73.00	Tentative settlement (for contractor use only)		0	73.00
73.01	Tentative settlement-PARHM (for contractor use only)		0	73.01
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		91,035	74.00
74.01	Balance due provider/program-PARHM (see instructions)		0	74.01
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		481,732	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	100.00
	HVBP Adjustment for HSP Bonus Payment			
101.00	HVBP adjustment factor (see instructions)		1.0080897677	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)		0	102.00
	HRR Adjustment for HSP Bonus Payment			
103.00	HRR adjustment factor (see instructions)		0.9842	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		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
	Comparison 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: 15-0075

Period:
From 10/01/2021
To 09/30/2022Worksheet E
Part A Exhibit 4
Date/Time Prepared:
2/28/2023 8:13 pm

			Title XVIII		Hospital		PPS	
		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	2.00	3.00		
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	0	0	0	0	0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	1,921,369	0		1,921,369	1,921,369	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	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	0	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	20,399	0		20,399	20,399	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	2,166,243	0	0	2,166,243	2,166,243	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	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	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	All allowable disproportionate share percentage (see instructions)	33.00	0.1078	0.1078	0.1078	0.1078	0.1078	10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	51,781	0	0	51,781	51,781	11.00
11.01	Uncompensated care payments	36.00	182,778	0	0	182,778	182,778	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	2,176,327	0	0	2,176,327	2,176,327	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	2,176,327	0	0	2,176,327	2,176,327	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	147,635	0	0	147,635	147,635	16.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 15-0075

Period:

From

10/01/2021

To

09/30/2022

Date/Time Prepared:

2/28/2023 8:13 pm

		Title XVIII		Hospital		PPS	
		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	61,116	0	0	61,116	61,116 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	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	0	2,385,078	2,385,078 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	141,142	0	0	141,142	141,142 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	6,493	0	0	6,493	6,493 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	147,635	0	0	147,635	147,635 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	0.207803	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				495,626	495,626 29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 15-0075

Period:
From 10/01/2021
To 09/30/2022Worksheet E
Part B
Date/Time Prepared:
2/28/2023 8:13 pm

Title XVIII

Hospital

PPS

1.00

PART B - MEDICAL AND OTHER HEALTH SERVICES

1.00	Medical and other services (see instructions)	3,186	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	3,570,071	2.00
3.00	OPPS payments	2,547,419	3.00
4.00	Outlier payment (see instructions)	0	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	3,186	11.00

COMPUTATION OF LESSER OF COST OR CHARGES

12.00	Reasonable charges	20,513	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	20,513	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 charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	20,513	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	17,327	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	3,186	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)	2,547,419	24.00

COMPUTATION OF REIMBURSEMENT SETTLEMENT

25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	1,573	25.00
26.00	Deductibles and coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	482,345	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)	2,066,687	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)	2,066,687	30.00
31.00	Primary payer payments	793	31.00
32.00	Subtotal (line 30 minus line 31)	2,065,894	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)	34,094	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	22,161	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	26,053	36.00
37.00	Subtotal (see instructions)	2,088,055	37.00
38.00	MSP-LCC reconciliation amount from PS&R	33	38.00
39.00	OTHER ADJUSTMENTS PS&R	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	39.50
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	2,088,022	40.00
40.01	Sequestration adjustment (see instructions)	15,660	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs	0	40.03
41.00	Interim payments	2,050,691	41.00
41.01	Interim payments-PARHM	0	41.01
42.00	Tentative settlement (for contractors use only)	0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)	0	42.01
43.00	Balance due provider/program (see instructions)	21,671	43.00
43.01	Balance due provider/program-PARHM (see instructions)	0	43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00

TO BE COMPLETED BY CONTRACTOR

90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

Health Financial Systems

CALCULATION OF REIMBURSEMENT SETTLEMENT

BLUFFTON REGIONAL MEDICAL CENTER

In Lieu of Form CMS-2552-10

	Provider CCN: 15-0075	Period: From 10/01/2021 To 09/30/2022	Worksheet E Part B Date/Time Prepared: 2/28/2023 8:13 pm
	Title XVIII	Hospital	PPS
		1.00	
MEDI CARE PART B ANCILLARY COSTS 200.00	Part B Combined Billed Days		0200.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-0075

Period:
From 10/01/2021
To 09/30/2022Worksheet E-1
Part I
Date/Time Prepared:
2/28/2023 8:13 pm

		Title XVIII		Hospital	PPS
		Inpatient Part A		Part B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount
		1.00	2.00	3.00	4.00
1.00	Total interim payments paid to provider			2,445,577	2,050,691
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
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
3.02				0	0
3.03				0	0
3.04				0	0
3.05				0	0
	Provider to Program				
3.50	ADJUSTMENTS TO PROGRAM			0	0
3.51				0	0
3.52				0	0
3.53				0	0
3.54				0	0
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)			0	0
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)			2,445,577	2,050,691
	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
5.02				0	0
5.03				0	0
	Provider to Program				
5.50	TENTATIVE TO PROGRAM			0	0
5.51				0	0
5.52				0	0
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	0
6.00	Determined net settlement amount (balance due) based on the cost report. (1)				6.00
6.01	SETTLEMENT TO PROVIDER			91,035	21,671
6.02	SETTLEMENT TO PROGRAM			0	0
7.00	Total Medicare program liability (see instructions)			2,536,612	2,072,362
				Contractor Number	NPR Date (Mo/Day/Yr)
8.00	Name of Contractor		0	1.00	2.00
					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-0075

Component CCN: 15-U075

Period:

From 10/01/2021

To 09/30/2022

Worksheet E-1

Part I

Date/Time Prepared:

2/28/2023 8:13 pm

PPS

		Title XVIII		Swing Beds - SNF	
		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		504,492		0
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
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
3.02			0		0
3.03			0		0
3.04			0		0
3.05			0		0
	Provider to Program				
3.50	ADJUSTMENTS TO PROGRAM		0		0
3.51			0		0
3.52			0		0
3.53			0		0
3.54			0		0
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0
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)		504,492		0
	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
5.02			0		0
5.03			0		0
	Provider to Program				
5.50	TENTATIVE TO PROGRAM		0		0
5.51			0		0
5.52			0		0
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0
6.00	Determined net settlement amount (balance due) based on the cost report. (1)				6.00
6.01	SETTLEMENT TO PROVIDER		0		0
6.02	SETTLEMENT TO PROGRAM		0		0
7.00	Total Medicare program liability (see instructions)		504,492		0
				Contractor Number	NPR Date (Mo/Day/Yr)
8.00	Name of Contractor		0	1.00	2.00
					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

Provider CCN: 15-0075

Period:
From 10/01/2021
To 09/30/2022Worksheet E-1
Part II
Date/Time Prepared:
2/28/2023 8:13 pm

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

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS		Provider CCN: 15-0075 Component CCN: 15-U075	Period: From 10/01/2021 To 09/30/2022	Worksheet E-2 Date/Time Prepared: 2/28/2023 8:13 pm
Title XVIII		Swing Beds - SNF	PPS	
		Part A	Part B	
COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient routine services - swing bed-SNF (see instructions)	544,459	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swing-bed pass-through, see instructions)	0	0	3.00
3.01	Nursing and allied health payment-PARHM (see instructions)			3.01
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	888	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0	7.00	
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	544,459	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	544,459	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	544,459	0	12.00
13.00	Coinurance billed to program patients (from provider records) (exclude coinurance for physician professional services)	36,052	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (see instructions)	508,407	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	16.50
16.55	Rural community hospital demonstration project (\$410A Demonstration) payment adjustment (see instructions)	0	0	16.55
16.99	Demonstration payment adjustment amount before sequestration	0	0	16.99
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	508,407	0	19.00
19.01	Sequestration adjustment (see instructions)	3,915	0	19.01
19.02	Demonstration payment adjustment amount after sequestration	0	0	19.02
19.03	Sequestration adjustment-PARHM pass-throughs		0	19.03
19.25	Sequestration for non-claims based amounts (see instructions)	0	0	19.25
20.00	Interim payments	504,492	0	20.00
20.01	Interim payments-PARHM		0	20.01
21.00	Tentative settlement (for contractor use only)	0	0	21.00
21.01	Tentative settlement-PARHM (for contractor use only)		0	21.01
22.00	Balance due provider/program (line 19 minus lines 19.01, 19.02, 19.25, 20, and 21)	0	0	22.00
22.01	Balance due provider/program-PARHM (see instructions)		0	22.01
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	23.00
Rural Community Hospital Demonstration Project (\$410A Demonstration) Adjustment				
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
Cost Reimbursement				
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))			201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))			202.00
203.00	Total (sum of lines 201 and 202)			203.00
204.00	Medicare swing-bed SNF discharges (see instructions)			204.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)				
205.00	Medicare swing-bed SNF target amount			205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)			206.00
Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement				
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)			208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
Comparison of PPS versus Cost Reimbursement				
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)			215.00

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

Provider CCN: 15-0075

Period:
From 10/01/2021
To 09/30/2022

Worksheet G
Date/Time Prepared:
2/28/2023 8:13 pm

	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund		
				1.00	2.00	3.00
CURRENT ASSETS						
1.00	Cash on hand in banks	-512,847	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	9,024,251	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	All allowances for uncollectible notes and accounts receivable	-2,261,869	0	0	0	6.00
7.00	Inventory	1,144,028	0	0	0	7.00
8.00	Prepaid expenses	528,765	0	0	0	8.00
9.00	Other current assets	-230,648	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	7,691,680	0	0	0	11.00
FIXED ASSETS						
12.00	Land	3,835,200	0	0	0	12.00
13.00	Land improvements	682,792	0	0	0	13.00
14.00	Accumulated depreciation	-532,816	0	0	0	14.00
15.00	Buildings	18,037,914	0	0	0	15.00
16.00	Accumulated depreciation	-11,077,401	0	0	0	16.00
17.00	Leasehold improvements	8,111,192	0	0	0	17.00
18.00	Accumulated depreciation	-5,100,825	0	0	0	18.00
19.00	Fixed equipment	3,651,711	0	0	0	19.00
20.00	Accumulated depreciation	-3,337,453	0	0	0	20.00
21.00	Automobiles and trucks	33,077	0	0	0	21.00
22.00	Accumulated depreciation	-33,077	0	0	0	22.00
23.00	Major movable equipment	11,851,379	0	0	0	23.00
24.00	Accumulated depreciation	-9,358,730	0	0	0	24.00
25.00	Minor equipment depreciation	6,660,084	0	0	0	25.00
26.00	Accumulated depreciation	-5,595,655	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)	17,827,392	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	1,529,914	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	1,529,914	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	27,048,986	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	1,401,142	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,673,112	0	0	0	38.00
39.00	Payroll taxes payable	109,460	0	0	0	39.00
40.00	Notes and loans payable (short term)	162,923	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	33,296,938	0	0	0	43.00
44.00	Other current liabilities	253,371	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	36,896,946	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	117,325	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	117,325	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	37,014,271	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	-9,965,285	0	0	0	52.00
53.00	Specific purpose fund		0	0	0	53.00
54.00	Donor created - endowment fund balance - restricted			0	0	54.00
55.00	Donor created - endowment fund balance - unrestricted			0	0	55.00
56.00	Governing body created - endowment fund balance			0	0	56.00
57.00	Plant fund balance - invested in plant			0	0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion			0	0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	-9,965,285	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	27,048,986	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 15-0075

Period:
From 10/01/2021
To 09/30/2022Worksheet G-1
Date/Time Prepared:
2/28/2023 8:13 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1. 00	2. 00	3. 00	4. 00	5. 00	
1. 00	Fund balances at beginning of period		-11,420,551			0	1. 00
2. 00	Net income (loss) (from Wkst. G-3, line 29)		283,911			0	2. 00
3. 00	Total (sum of line 1 and line 2)		-11,136,640			0	3. 00
4. 00	Additions (credit adjustments) (specify)	0		0		0	4. 00
5. 00		0		0		0	5. 00
6. 00		0		0		0	6. 00
7. 00		0		0		0	7. 00
8. 00		0		0		0	8. 00
9. 00		0		0		0	9. 00
10. 00	Total additions (sum of line 4-9)		0		0	0	10. 00
11. 00	Subtotal (line 3 plus line 10)		-11,136,640			0	11. 00
12. 00	PLUG TO RE	0		0		0	12. 00
13. 00		0		0		0	13. 00
14. 00		0		0		0	14. 00
15. 00		0		0		0	15. 00
16. 00		0		0		0	16. 00
17. 00		0		0		0	17. 00
18. 00	Total deductions (sum of lines 12-17)		0		0	0	18. 00
19. 00	Fund balance at end of period per balance sheet (line 11 minus line 18)		-11,136,640			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)	0		0			2. 00
3. 00	Total (sum of line 1 and line 2)	0		0			3. 00
4. 00	Additions (credit adjustments) (specify)		0				4. 00
5. 00			0				5. 00
6. 00			0				6. 00
7. 00			0				7. 00
8. 00			0				8. 00
9. 00			0				9. 00
10. 00	Total additions (sum of line 4-9)	0		0			10. 00
11. 00	Subtotal (line 3 plus line 10)	0		0			11. 00
12. 00	PLUG TO RE		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: 15-0075

Period:

From 10/01/2021

To 09/30/2022

Worksheet G-2

Parts I & II

Date/Time Prepared:

2/28/2023 8:13 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital			12,566,267	12,566,267
2.00	SUBPROVIDER - IPF				1.00
3.00	SUBPROVIDER - IRF				2.00
4.00	SUBPROVIDER				3.00
5.00	Swing bed - SNF		0		4.00
6.00	Swing bed - NF		0		5.00
7.00	SKILLED NURSING FACILITY		0		6.00
8.00	NURSING FACILITY				7.00
9.00	OTHER LONG TERM CARE				8.00
10.00	Total general inpatient care services (sum of lines 1-9)			12,566,267	9.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT			583,721	10.00
12.00	CORONARY CARE UNIT				11.00
13.00	BURN INTENSIVE CARE UNIT				12.00
14.00	SURGICAL INTENSIVE CARE UNIT				13.00
15.00	OTHER SPECIAL CARE (SPECIFY)				14.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)		583,721		15.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)		13,149,988		16.00
18.00	Ancillary services	36,470,156	139,495,817	175,965,973	17.00
19.00	Outpatient services	3,336,035	21,771,879	25,107,914	18.00
20.00	RURAL HEALTH CLINIC	0	0	0	19.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	20.00
22.00	HOME HEALTH AGENCY	0	0	0	21.00
23.00	AMBULANCE SERVICES	0	0	0	22.00
24.00	CMHC	0	0	0	23.00
25.00	AMBULATORY SURGICAL CENTER (D. P.)	0	0	0	24.00
26.00	HOSPICE	0	0	0	25.00
27.00	IP CONTRACTED HOSPICE	21,910	0	21,910	26.00
28.00	Total patient revenues (sum of lines 17-27) (transfer column 3 to Wkst. G-3, line 1)	52,978,089	161,267,696	214,245,785	27.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)			41,412,242	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)			41,412,242	43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 15-0075

Period:
From 10/01/2021
To 09/30/2022Worksheet G-3
Date/Time Prepared:
2/28/2023 8:13 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	214,245,785	1.00
2.00	Less contractual allowances and discounts on patients' accounts	174,019,904	2.00
3.00	Net patient revenues (line 1 minus line 2)	40,225,881	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	41,412,242	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-1,186,361	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER INCOME	1,470,272	24.00
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	1,470,272	25.00
26.00	Total (line 5 plus line 25)	283,911	26.00
27.00	OTHER EXPENSE	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)	283,911	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 15-0075	Period: From 10/01/2021 To 09/30/2022	Worksheet L Parts I-III Date/Time Prepared: 2/28/2023 8:13 pm
		Title XVIII	Hospital	PPS
				1.00
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		141,142	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		6,493	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)		9.30	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)		147,635	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