

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 use only	1. <input checked="" type="checkbox"/> Electronically prepared cost report	Date: 2/28/2023	Time: 8:13 pm
	2. <input type="checkbox"/> Manually prepared cost report		
	3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.		
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.

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

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by 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	2		
1			I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name			2
3	Signatory Title	VICE PRESIDENT		3
4	Date			4

Cost Center Description	Title V	Title XVIII		HIT	Title XIX	
		Part A	Part B			
	1.00	2.00	3.00	4.00	5.00	
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	91,035	21,671	0	0	1.00
2.00 Subprovider - IPF	0	0	0		0	2.00
3.00 Subprovider - IRF	0	0	0		0	3.00
5.00 Swing Bed - SNF	0	0	0		0	5.00
6.00 Swing Bed - NF	0				0	6.00
7.00 SKILLED NURSING FACILITY	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:				1.00	
2.00	City: BLUFFTON			State: IN		Zip Code: 46714-		County: WELLS 2.00	
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)	
								V	XVIII
								XIX	
		1.00		2.00	3.00	4.00	5.00	6.00	7.00
								8.00	
Hospital and Hospital-Based Component Identification:									
3.00	Hospital			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

Worksheet S-2
Part I
Date/Time Prepared:
2/28/2023 8:13 pm

MCRI F32 - 17.13.175.6

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	IME	Direct GME
			1.00	2.00	3.00	4.00	5.00
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)		N			0.00	0.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).						61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06
			Program Name		Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count
			1.00		2.00	3.00	4.00
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.					0.00	0.00
61.20	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
						1.00	
62.00	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)					0.00	62.00
62.01	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	62.01
63.00	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)						
			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 Nonprovi der Site	Unweighted FTEs in Hospi tal	Ratio (col. 1/ (col. 1 + col. 2))		
			1.00	2.00	3.00		
64.00	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. 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	0.000000
						0.00	64.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 15-0075

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

	Program Name	Program Code	Unweighted FTEs Nonprovi der Si te	Unweighted FTEs in Hospi tal	Ratio (col. 3/ (col. 3 + col. 4))	
	1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	65.00
			Unweighted FTEs Nonprovi der Si te	Unweighted FTEs in Hospi tal	Ratio (col. 1/ (col. 1 + col. 2))	
			1.00	2.00	3.00	
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					
	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
			Unweighted FTEs Nonprovi der Si te	Unweighted FTEs in Hospi tal	Ratio (col. 3/ (col. 3 + col. 4))	
			1.00	2.00	5.00	
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	67.00
			1.00	2.00	3.00	
70.00	Inpatient Psychiatric Facility PPS					
	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.		N			70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)					
					0	71.00
	Inpatient Rehabilitation Facility PPS					
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.					
	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)					
			N		0	75.00
76.00						
						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
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			1.00			
Long Term Care Hospital PPS						
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.		N	80.00		
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.		N	81.00		
TEFRA Providers						
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.		N	85.00		
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			86.00		
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.		N	87.00		
		V	XIX			
		1.00	2.00			
Title V and XIX Services						
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00		
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00		
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00		
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00		
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00		
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00		
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00		
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00		
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.00		
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. 1? 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. 1 through 1V? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.06		
Rural Providers						
105.00	Does this hospital qualify as a CAH?	N		105.00		
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106.00		
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)			107.00		
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00		
		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.				N	109.00
					1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.				N	110.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0075	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	3.00
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N		112.00
Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		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			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
Transplant Center Information				
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
All Providers				
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	HB1848	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 15-0075		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:				
143.00	City: FRANKLIN				State: TN		Zip Code: 37067		
									1.00
144.00	Are provider based physicians' costs included in Worksheet A?								Y
									1.00
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.							N	145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.							N	146.00
									1.00
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.								N
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.								N
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.								N
				Part A	Part B	Title V	Title XIX		
				1.00	2.00	3.00	4.00		
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)									
155.00	Hospital			N	N	N	N		
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		
									1.00
Multicampus									
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.								N
				Name	County	State	Zip Code	CBSA	FTE/Campus
				0	1.00	2.00	3.00	4.00	5.00
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)								0.00
									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
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)								
168.01	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)								
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
						Beginning	Ending		
						1.00	2.00		
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)								170.00
						1.00	2.00		
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)						N		0

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	Date		
				1.00	2.00		
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.							
COMPLETED BY ALL HOSPITALS							
Provider Organization and Operation							
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)			N			1.00
				Y/N	Date	V/I	
				1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.			N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)			N			3.00
				Y/N	Type	Date	
				1.00	2.00	3.00	
Financial Data and Reports							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.			N			4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.			N			5.00
				Y/N		Legal Oper.	
				1.00		2.00	
Approved Educational Activities							
6.00	Column 1: Are costs claimed for a nursing program? Column 2: If yes, is the provider is the legal operator of the program?			N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.			N			7.00
8.00	Were nursing programs and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.			N			8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.			N			9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.			N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.			N			11.00
						Y/N	
						1.00	
Bad Debts							
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.					Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.					N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.					N	14.00
Bed Complement							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.					Y	15.00
				Part A		Part B	
				Y/N	Date	Y/N	Date
				1.00	2.00	3.00	4.00
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)			Y	01/19/2023	Y	01/19/2023
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	
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	
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	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 15-0075

Period:
From 10/01/2021
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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	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions		N		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		N		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		Y		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		N		25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		N		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		N		27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		N		28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions		N		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		N		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		N		31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		N		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		N		33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		N		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		N		35.00
			Y/N	Date	
			1.00	2.00	
Home Office Costs					
36.00	Were home office costs claimed on the cost report?		Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		Y		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		Y	12/31/2021	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N		40.00
			1.00	2.00	
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	KUZI WA		TSI GA	41.00
42.00	Enter the employer/company name of the cost report preparer.	CHS			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	615-465-3416		KUZI WA_TSI GA@CHS. NET	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 15-0075

Period:
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		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 09/30/2022Worksheet 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				0	13.00
14.00 Total (see instructions)		54	19,710	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	44.00	0	0		0	19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		54			0	27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00
33.01 LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 15-0075

Period:
From 10/01/2021
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Part I
Date/Time Prepared:
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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		243	427			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	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)				0.00	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 instruction)			44			30.00
31.00	Employee discount days - IRF			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			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 15-0075

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

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

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0075

Period:
From 10/01/2021
To 09/30/2022Worksheet 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	
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
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician and Non-Physician-Part B		0	0	0	0.00	0.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00
9.00	SNF	44.00	0	0	0	0.00	0.00
10.00	Excluded area salaries (see instructions)		107	-107	0	0.00	0.00
OTHER WAGES & RELATED COSTS							
11.00	Contract Labor: Direct Patient Care		2,581,994	0	2,581,994	20,349.00	126.89
12.00	Contract Labor: Top level management and other management and administrative services		0	0	0	0.00	0.00
13.00	Contract Labor: Physician-Part A - Administrative		103,570	0	103,570	839.35	123.39
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00
14.01	Home office salaries		1,265,859	0	1,265,859	31,246.00	40.51
14.02	Related organization salaries		0	0	0	0.00	0.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00
16.02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00
WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		3,431,014	0	3,431,014		
18.00	Wage-related costs (other) (see instructions)						
19.00	Excluded areas		0	0	0		
20.00	Non-physician anesthetist Part A		0	0	0		
21.00	Non-physician anesthetist Part B		0	0	0		
22.00	Physician Part A - Administrative		0	0	0		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		0	0	0		
24.00	Wage-related costs (RHC/FQHC)		0	0	0		
25.00	Interns & residents (in an approved program)		0	0	0		
25.50	Home office wage-related (core)		299,182	0	299,182		
25.51	Related organization wage-related (core)		0	0	0		
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0		

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0075

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

		Wkst. A Line Number	Amount Reported	Recl assi fi cati on 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	26.00
27.00	Administrative & General	5.00	1,613,480	-288,412	1,325,068	52,378.00	25.30	27.00
28.00	Administrative & General under contract (see inst.)		57,091	0	57,091	368.53	154.92	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	294,217	0	294,217	10,286.00	28.60	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	325,374	0	325,374	18,960.00	17.16	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	954	-761	193	5.26	36.69	34.00
35.00	Dietary under contract (see instructions)		792,170	0	792,170	50,073.96	15.82	35.00
36.00	Cafeteria	11.00	0	761	761	20.74	36.69	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	579,037	288,412	867,449	20,498.00	42.32	38.00
39.00	Central Services and Supply	14.00	163,588	0	163,588	7,313.00	22.37	39.00
40.00	Pharmacy	15.00	582,668	0	582,668	11,587.00	50.29	40.00
41.00	Medical Records & Medical Records Library	16.00	185,734	0	185,734	7,003.00	26.52	41.00
42.00	Social Service	17.00	183,872	0	183,872	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0075

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

	Worksheet A Line Number	Amount Reported	Recl assi fi cati on 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 09/30/2022	Worksheet S-3 Part IV Date/Time Prepared: 2/28/2023 8:13 pm
				Amount Reported
				1.00
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)			25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 15-0075

Period:
From 10/01/2021
To 09/30/2022Worksheet S-3
Part V
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

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 15-0075	Period: From 10/01/2021 To 09/30/2022	Worksheet S-10 Date/Time Prepared: 2/28/2023 8:13 pm	
				1.00	
Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.168917		1.00
Medicaid (see instructions for each line)					
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
Children's Health Insurance Program (CHIP) (see instructions for each line)					
9.00	Net revenue from stand-alone CHIP		0		9.00
10.00	Stand-alone CHIP charges		0		10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)		0		11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)		0		12.00
Other state or local government indigent care program (see instructions for each line)					
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0		13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0		14.00
15.00	State or local indigent care program cost (line 1 times line 14)		0		15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)		0		16.00
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)					
17.00	Private grants, donations, or endowment income restricted to funding charity care		0		17.00
18.00	Government grants, appropriations or transfers for support of hospital operations		0		18.00
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		0		19.00
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
Uncompensated Care (see instructions for each line)					
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	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

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

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassification (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	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		3,338,687	3,338,687	134,745	3,473,432	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	76,253	64,707	140,960	2,588,158	2,729,118	4.00
5.01	01160	COMMUNICATIONS	0	0	0	399,041	399,041	5.01
5.02	00540	ADMINISTRATIVE	0	0	0	597,294	597,294	5.02
5.03	00550	CASHIERING/ACCOUNTS RECEIVABLE	0	0	0	752,045	752,045	5.03
5.04	00560	OTHER ADMINISTRATIVE AND GENERAL	1,613,480	11,356,973	12,970,453	-5,168,870	7,801,583	5.04
7.00	00700	OPERATION OF PLANT	294,217	1,317,816	1,612,033	484,575	2,096,608	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	113,435	113,435	0	113,435	8.00
9.00	00900	HOUSEKEEPING	325,374	122,188	447,562	-7,555	440,007	9.00
10.00	01000	DIETARY	954	984,387	985,341	-796,908	188,433	10.00
11.00	01100	CAFETERIA	0	0	0	785,983	785,983	11.00
13.00	01300	NURSING ADMINISTRATION	579,037	124,914	703,951	288,404	992,355	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	163,588	228,845	392,433	581	393,014	14.00
15.00	01500	PHARMACY	582,668	1,480,429	2,063,097	-1,320,781	742,316	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	185,734	292,427	478,161	0	478,161	16.00
17.00	01700	SOCIAL SERVICE	183,872	74,823	258,695	-115	258,580	17.00
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	30.00
31.00	03100	INTENSIVE CARE UNIT	145,971	299,699	445,670	-228	445,442	31.00
43.00	04300	NURSERY	0	0	0	584,937	584,937	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,275,887	2,096,072	3,371,959	-589,049	2,782,910	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	463,051	463,051	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,080,934	455,729	1,536,663	-240,347	1,296,316	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	45,595	70,341	115,936	-1,052	114,884	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	1,005,271	1,217,930	2,223,201	-77,414	2,145,787	60.00
65.00	06500	RESPIRATORY THERAPY	324,876	52,340	377,216	-1,871	375,345	65.00
66.00	06600	PHYSICAL THERAPY	540,403	56,742	597,145	0	597,145	66.00
67.00	06700	OCCUPATIONAL THERAPY	312,892	26,817	339,709	-4,228	335,481	67.00
68.00	06800	SPEECH PATHOLOGY	151,110	11,261	162,371	0	162,371	68.00
69.00	06900	ELECTROCARDIOLOGY	189,775	25,521	215,296	-242	215,054	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	102,062	102,062	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	253,023	253,023	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,139,765	1,139,765	73.00
76.00	03950	OTHER ANCILLARY	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	32,391	12,082	44,473	-205	44,268	76.01
76.03	03953	WOUND CARE	63,740	14,367	78,107	0	78,107	76.03
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	912,116	1,735,292	2,647,408	-1,761	2,645,647	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	107	8	115	-115	0	95.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	12,474,142	28,938,100	41,412,242	0	41,412,242	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 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		TOTAL (SUM OF LINES 118 through 199)	12,474,142	28,938,100	41,412,242	0	41,412,242	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-0075

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

Worksheet A

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

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-79,678	1,757,738	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-830,677	2,642,755	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-472	2,728,646	4.00
5.01	01160	COMMUNICATIONS	-3,420	395,621	5.01
5.02	00540	ADMINISTRATIVE	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

RECLASSIFICATIONS

Provider CCN: 15-0075

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

Worksheet A-6

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

		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		1.00
	TOTALS		0	2,589,095		
	B - RECLASS RENTAL AND LEASE EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	404,399		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	127,257		2.00
3.00	OTHER ADMINI STRATIVE AND GENERAL	5.04	0	620		3.00
4.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,251		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
	TOTALS		0	533,527		
	C - RECLASS OTHER CAPITAL COSTS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	156,806		1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	191,710		2.00
3.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	7,488		3.00
	TOTALS		0	356,004		
	D - RECLASS REPAIRS & MAINTENANCE					
1.00	OPERATION OF PLANT	7.00	0	439,133		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
	TOTALS		0	439,133		
	E - RECLASS CNO COSTS					
1.00	NURSING ADMINI STRATION	13.00	288,412	0		1.00
	TOTALS		288,412	0		
	F - RECLASS MEDICAL SUPPLIES					
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	107,760		1.00
2.00	MEDI CAL SUPPLIES CHARGED TO PATIENT	71.00	0	102,062		2.00
3.00	IMPL. DEV. CHARGED TO PATI ENTS	72.00	0	253,023		3.00
	TOTALS		0	462,845		
	G - RECLASS COST OF DRUGS/IV SOLUTI ONS					
1.00	DRUGS CHARGED TO PATI ENTS	73.00	0	1,139,765		1.00
	TOTALS		0	1,139,765		
	H - RECLASS LABOR AND DELIVERY COSTS					
1.00	NURSERY	43.00	300,121	284,816		1.00
2.00	DELI VERY ROOM & LABOR ROOM	52.00	237,584	225,467		2.00
	TOTALS		537,705	510,283		
	I - RECLASS A PORTION OF DIETARY TO CAFE					
1.00	CAFETERI A	11.00	761	785,222		1.00
	TOTALS		761	785,222		
	J - RECLASS ADMIN AND GENERAL COSTS					
1.00	COMMUNI CATIONS	5.01	95,250	303,791		1.00
2.00	ADMI TTI NG	5.02	484,794	112,500		2.00
3.00	CASHI ERI NG/ACCOUNTS RECEI VABLE	5.03	0	752,045		3.00
4.00	EMERGENCY	91.00	107	8		4.00
	TOTALS		580,151	1,168,344		
	K - NON-CAPI TALI ZED EQUIPMENT					
1.00	OPERATION OF PLANT	7.00	0	57,041		1.00
2.00	OTHER ADMI NI STRATI VE AND GENERAL	5.04	0	1,088		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00

RECLASSIFICATIONS

Provider CCN: 15-0075

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

Worksheet A-6

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

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

RECLASSIFICATIONS

Provider CCN: 15-0075

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	RADIOISOTOPE	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			
	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			
	G - RECLASS COST OF DRUGS/IV SOLUTIONS						
1.00	PHARMACY	15.00	0	1,139,765	0		1.00
	TOTALS		0	1,139,765			
	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			
	I - RECLASS A PORTION OF DIETARY TO CAFE						
1.00	DIETARY	10.00	761	785,222	0		1.00
	TOTALS		761	785,222			
	J - RECLASS ADMIN 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			
	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

RECLASSIFICATIONS

Provider CCN: 15-0075

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

Worksheet A-6

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

Decreases						Wkst. A-7 Ref.	
	Cost Center	Line #	Salary	Other			
	6.00	7.00	8.00	9.00	10.00		
4.00	OPERATING ROOM	50.00	0	1,100	0		4.00
5.00	OCCUPATIONAL THERAPY	67.00	0	4,228	0		5.00
	TOTALS		0	58,129			
500.00	Grand Total: Decreases		1,407,029	8,042,347			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0075

Period:
From 10/01/2021
To 09/30/2022Worksheet A-7
Part I
Date/Time Prepared:
2/28/2023 8:13 pm

		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				1.00
2.00	Land Improvements	682,793	0				2.00
3.00	Buildings and Fixtures	17,993,755	0				3.00
4.00	Building Improvements	8,155,351	0				4.00
5.00	Fixed Equipment	3,651,711	0				5.00
6.00	Movable Equipment	30,771,113	0				6.00
7.00	HIT designated Assets	3,484,781	0				7.00
8.00	Subtotal (sum of lines 1-7)	68,574,704	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	68,574,704	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0075

Period:
From 10/01/2021
To 09/30/2022Worksheet A-7
Part II
Date/Time Prepared:
2/28/2023 8:13 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	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 Capital-Related Costs (see instructions)	Total (1) (sum of col.s. 9 through 14)				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	1,083,250				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 09/30/2022Worksheet 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	
	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-MVBLE 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
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital -Related Costs	Total (sum of col.s. 5 through 7)	Depreciation	Lease	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	885,343	405,650	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	2,507,385	127,257	2.00
3.00	Total (sum of lines 1-2)	0	0	0	3,392,728	532,907	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital -Related Costs (see instructions)	Total (2) (sum of col.s. 9 through 14)	
	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-MVBLE 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

ADJUSTMENTS TO EXPENSES

Provider CCN: 15-0075

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

Worksheet A-8

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

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	
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		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-1,703	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	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	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

ADJUSTMENTS TO EXPENSES

Provider CCN: 15-0075

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

Worksheet A-8

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

			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	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 MISC 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 PHYSICIAN 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

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

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:						
1.00		1.00	CAP REL COSTS-BLDG & FIXT	CAPITAL-RELATED INTEREST	115,239	0
2.00		1.00	CAP REL COSTS-BLDG & FIXT	PASI CAPITAL COSTS - BLDG &	2,990	0
3.00		2.00	CAP REL COSTS-MVBLE EQUIP	PASI CAPITAL COSTS - MOVEABL	625	0
4.00		5.04	OTHER ADMINISTRATIVE AND GEN	PASI OPERATING COSTS	213,570	164,767
4.01		5.04	OTHER ADMINISTRATIVE AND GEN	SHARED SERVICE CENTER ALLOCA	994,733	645,684
4.02		1.00	CAP REL COSTS-BLDG & FIXT	NEW CAPITAL - BUILDING & FIX	35,479	0
4.03		2.00	CAP REL COSTS-MVBLE EQUIP	NEW CAPITAL - MOVABLE EQUIPM	74,511	0
4.04		5.04	OTHER ADMINISTRATIVE AND GEN	NON-CAPITAL HOME OFFICE COST	1,386,849	0
4.05		5.04	OTHER ADMINISTRATIVE AND GEN	MALPRACTICE COSTS	230,522	181,551
4.06		5.04	OTHER ADMINISTRATIVE AND GEN	MANAGEMENT FEES	0	837,954
4.07		5.04	OTHER ADMINISTRATIVE AND GEN	401K FEES	0	4,775
4.08		5.04	OTHER ADMINISTRATIVE AND GEN	AUDIT FEES	0	27,993
4.09		5.04	OTHER ADMINISTRATIVE AND GEN	CORPORATE OVERHEAD ALLOCATIO	0	575,809
4.10		5.04	OTHER ADMINISTRATIVE AND GEN	HIM ALLOCATION	0	254,954
4.11		5.04	OTHER ADMINISTRATIVE AND GEN	CONTRACT MANAGEMENT	0	73,388
4.12		5.04	OTHER ADMINISTRATIVE AND GEN	PASI LIEN UNIT COLLECTION FE	0	13,933
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

* 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	4.00	5.00
B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:					

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

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

6.00	B	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 09/30/2022

Worksheet 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 ORGANIZATION(S) AND/OR HOME OFFICE:			

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

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

6.00	HOSPITAL 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

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

Worksheet A-8-2

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	1.00
2.00	50.00	OPERATING ROOM	115,150	115,150	0	0	0	2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	26,563	26,563	0	0	0	3.00
4.00	91.00	EMERGENCY	712,872	712,872	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,481,208	1,481,208	0	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	1.00
2.00	50.00	OPERATING ROOM	0	0	0	0	0	2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	3.00
4.00	91.00	EMERGENCY	0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	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			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	COMMUNICATIONS	
			Net Expenses for Cost Allocation (from Wkst A col. 7)	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	426,872
5.02	00540	ADMINISTRATIVE	597,294	7,491	11,263	107,346	7,125
5.03	00550	CASHIERING/ACCOUNTS RECEIVABLE	752,045	10,354	15,567	0	5,182
5.04	00560	OTHER ADMINISTRATIVE AND GENERAL	5,324,803	176,850	265,893	164,968	33,683
7.00	00700	OPERATION OF PLANT	2,082,080	651,265	979,175	65,148	7,773
8.00	00800	LAUNDRY & LINEN SERVICE	113,435	0	0	0	648
9.00	00900	HOUSEKEEPING	440,007	8,406	12,639	72,047	1,296
10.00	01000	DIETARY	188,433	47,784	71,843	43	5,830
11.00	01100	CAFETERIA	785,983	0	0	169	0
13.00	01300	NURSING ADMINISTRATION	973,713	8,678	13,047	192,077	1,943
14.00	01400	CENTRAL SERVICES & SUPPLY	393,014	34,740	52,231	36,223	3,239
15.00	01500	PHARMACY	742,316	14,784	22,227	129,018	7,125
16.00	01600	MEDICAL RECORDS & LIBRARY	478,004	56,670	85,204	41,127	16,194
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	12,955
31.00	03100	INTENSIVE CARE UNIT	445,442	19,666	29,568	32,322	3,239
43.00	04300	NURSERY	584,937	0	0	66,455	648
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	2,667,760	120,977	181,888	282,516	22,024
51.00	05100	RECOVERY ROOM	0	0	0	0	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	463,051	0	0	52,608	1,296
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,269,753	98,330	147,840	239,348	13,603
54.01	03630	ULTRA SOUND	0	0	0	0	0
56.00	05600	RADIOISOTOPE	114,884	5,209	7,831	10,096	1,296
57.00	05700	CT SCAN	0	0	0	0	0
58.00	05800	MRI	0	0	0	0	0
60.00	06000	LABORATORY	2,145,787	40,256	60,525	222,594	12,307
65.00	06500	RESPIRATORY THERAPY	375,345	6,966	10,473	71,936	1,943
66.00	06600	PHYSICAL THERAPY	597,145	54,215	81,513	119,660	3,239
67.00	06700	OCCUPATIONAL THERAPY	335,481	0	0	69,283	0
68.00	06800	SPEECH PATHOLOGY	162,371	0	0	33,460	0
69.00	06900	ELECTROCARDIOLOGY	215,054	4,964	7,463	42,021	3,887
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	102,062	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	253,023	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	1,139,765	0	0	0	0
76.00	03950	OTHER ANCILLARY	0	0	0	0	0
76.01	03951	SLEEP LAB	44,268	4,946	7,436	7,172	0
76.03	03953	WOUND CARE	78,107	0	0	14,114	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	0
91.00	09100	EMERGENCY	1,932,775	41,850	62,922	201,991	11,012
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					
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)	36,502,788	1,757,738	2,642,755	2,745,224	177,487
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, 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	0
194.01	07955	MARKETING	0	0	0	0	0
194.02	07952	SENIOR CIRCLE	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					
201.00		Negative Cost Centers		0	0	0	0
202.00		TOTAL (sum lines 118 through 201)	36,502,788	1,757,738	2,642,755	2,745,224	426,872

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	ADMINISTRATIVE	Subtotal	CASHIERING/ACCOUNTS RECEIVABLE	Subtotal	
			5A.01	5.02	5A.02	5.03	5A.03	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01160	COMMUNICATIONS						5.01
5.02	00540	ADMINISTRATIVE	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	5.04
7.00	00700	OPERATION OF PLANT	3,785,441	77,302	3,862,743	86,460	3,949,203	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	114,083	2,330	116,413	2,606	119,019	8.00
9.00	00900	HOUSEKEEPING	534,395	10,913	545,308	12,206	557,514	9.00
10.00	01000	DIETARY	313,933	6,411	320,344	7,170	327,514	10.00
11.00	01100	CAFETERIA	786,152	16,054	802,206	17,956	820,162	11.00
13.00	01300	NURSING ADMINISTRATION	1,189,458	24,290	1,213,748	27,167	1,240,915	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	519,447	10,608	530,055	11,864	541,919	14.00
15.00	01500	PHARMACY	915,470	18,695	934,165	20,909	955,074	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	677,199	13,829	691,028	15,467	706,495	16.00
17.00	01700	SOCIAL SERVICE	303,149	6,191	309,340	6,924	316,264	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	4,172,894	85,215	4,258,109	95,309	4,353,418	30.00
31.00	03100	INTENSIVE CARE UNIT	530,237	10,828	541,065	12,111	553,176	31.00
43.00	04300	NURSERY	652,040	13,315	665,355	14,893	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	66,882	3,342,047	74,805	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	10,557	527,512	11,807	539,319	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,768,874	36,122	1,804,996	40,401	1,845,397	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	139,316	2,845	142,161	3,182	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	50,674	2,532,143	56,677	2,588,820	60.00
65.00	06500	RESPIRATORY THERAPY	466,663	9,530	476,193	10,659	486,852	65.00
66.00	06600	PHYSICAL THERAPY	855,772	17,476	873,248	19,546	892,794	66.00
67.00	06700	OCCUPATIONAL THERAPY	404,764	8,266	413,030	9,245	422,275	67.00
68.00	06800	SPEECH PATHOLOGY	195,831	3,999	199,830	4,473	204,303	68.00
69.00	06900	ELECTROCARDIOLOGY	273,389	5,583	278,972	6,244	285,216	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	102,062	2,084	104,146	2,331	106,477	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	253,023	5,167	258,190	5,779	263,969	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,139,765	23,275	1,163,040	26,032	1,189,072	73.00
76.00	03950	OTHER ANCILLARY	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	63,822	1,303	65,125	1,458	66,583	76.01
76.03	03953	WOUND CARE	92,221	1,883	94,104	2,106	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	45,958	2,296,508	51,403	2,347,911	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	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)	36,253,403	725,426	36,248,310	793,445	36,242,614	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,591	53	2,644	59	2,703	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	246,794	5,040	251,834	5,637	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 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		0		0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
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	
			5.04	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	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	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	10.00
11.00	01100	CAFETERIA	168,599	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	255,092	45,851	0	6,966	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	111,401	183,549	0	27,884	0	14.00
15.00	01500	PHARMACY	196,333	78,110	0	11,866	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	145,233	299,422	0	45,487	0	16.00
17.00	01700	SOCIAL SERVICE	65,014	8,136	0	1,236	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	894,936	1,749,485	56,709	265,779	685,665	30.00
31.00	03100	INTENSIVE CARE UNIT	113,715	103,908	80	15,785	0	31.00
43.00	04300	NURSERY	139,837	0	0	0	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	702,395	639,192	26,078	97,104	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	110,867	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	379,355	519,538	18,584	78,927	0	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	29,878	27,520	0	4,181	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	532,179	212,697	0	32,312	0	60.00
65.00	06500	RESPIRATORY THERAPY	100,081	36,806	1,287	5,591	0	65.00
66.00	06600	PHYSICAL THERAPY	183,530	286,452	301	43,517	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	86,806	0	2,640	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	41,998	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	58,631	26,228	0	3,985	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	21,888	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	54,264	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	244,435	0	0	0	0	73.00
76.00	03950	OTHER ANCILLARY	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	13,687	26,132	0	3,970	0	76.01
76.03	03953	WOUND CARE	19,778	0	4,641	0	0	76.03
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	482,655	221,121	33,165	33,592	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)	6,170,816	4,761,033	143,485	716,537	685,665	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	556	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	52,928	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)	6,224,300	4,761,033	143,485	716,537	685,665	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0075

Period:
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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-MVBLE 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	1,222,146	16.00
17.00	01700	SOCIAL SERVICE	17,422	0	400	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	172,416	750,340	63,887	0	78,423	30.00
31.00	03100	INTENSIVE CARE UNIT	11,790	49,074	388	0	3,330	31.00
43.00	04300	NURSERY	25,156	0	0	0	5,181	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	114,068	402,169	277,817	0	193,640	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	19,900	0	0	0	4,101	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	109,937	3,382	35,665	0	233,848	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	5,332	0	19,675	0	7,560	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	135,319	0	205,690	0	265,992	60.00
65.00	06500	RESPIRATORY THERAPY	31,089	0	11,983	0	19,610	65.00
66.00	06600	PHYSICAL THERAPY	57,822	0	5,403	0	25,573	66.00
67.00	06700	OCCUPATIONAL THERAPY	34,543	0	1,227	0	20,640	67.00
68.00	06800	SPEECH PATHOLOGY	13,292	0	349	0	7,028	68.00
69.00	06900	ELECTROCARDIOLOGY	19,975	61,369	1,364	0	43,517	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	77,525	0	63,452	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	113,951	0	20,831	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,318,263	93,356	73.00
76.00	03950	OTHER ANCILLARY	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	2,703	0	1,592	0	2,425	76.01
76.03	03953	WOUND CARE	7,359	20,925	3,810	0	2,267	76.03
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	1,181	90.00
91.00	09100	EMERGENCY	76,145	302,491	35,205	0	130,191	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)	988,761	1,589,750	891,186	1,318,263	1,222,146	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 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)	988,761	1,589,750	891,186	1,318,263	1,222,146	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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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-MVBLE 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					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	RADIOLOGY-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	RADIOISOTOPE	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			0		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 CIRCLE	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

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Cost Center Description			CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	2A	4.00
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	6,622	9,956	16,578	4.00
5.01	01160	COMMUNICATIONS	0	4,058	6,102	10,160	5.01
5.02	00540	ADMINISTRATIVE	0	7,491	11,263	18,754	5.02
5.03	00550	CASHIERING/ACCOUNTS RECEIVABLE	0	10,354	15,567	25,921	5.03
5.04	00560	OTHER ADMINISTRATIVE AND GENERAL	0	176,850	265,893	442,743	5.04
7.00	00700	OPERATION OF PLANT	0	651,265	979,175	1,630,440	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	8,406	12,639	21,045	9.00
10.00	01000	DIETARY	0	47,784	71,843	119,627	10.00
11.00	01100	CAFETERIA	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	8,678	13,047	21,725	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	34,740	52,231	86,971	14.00
15.00	01500	PHARMACY	0	14,784	22,227	37,011	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	56,670	85,204	141,874	16.00
17.00	01700	SOCIAL SERVICE	0	1,540	2,315	3,855	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	331,117	497,834	828,951	30.00
31.00	03100	INTENSIVE CARE UNIT	0	19,666	29,568	49,234	31.00
43.00	04300	NURSERY	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	120,977	181,888	302,865	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	98,330	147,840	246,170	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	5,209	7,831	13,040	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	40,256	60,525	100,781	60.00
65.00	06500	RESPIRATORY THERAPY	0	6,966	10,473	17,439	65.00
66.00	06600	PHYSICAL THERAPY	0	54,215	81,513	135,728	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	4,964	7,463	12,427	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	0	4,946	7,436	12,382	76.01
76.03	03953	WOUND CARE	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	41,850	62,922	104,772	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0	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)	0	1,757,738	2,642,755	4,400,493	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	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 CIRCLE	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	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	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0075

Period:
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Cost Center Description			COMMUNICATIONS	ADMINITTING	CASHIERING/ACCOUNTS RECEIVABLE	OTHER ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	
			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-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01160	COMMUNICATIONS	10,287					5.01
5.02	00540	ADMINITTING	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	RADIOISOTOPE	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	GIFT, 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 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)	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
Date/Time Prepared:
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Cost Center Description		LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
		8.00	9.00	10.00	11.00	13.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	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	1,942				8.00
9.00	00900	HOUSEKEEPING	0	46,348			9.00
10.00	01000	DIETARY	0	2,481	217,431		10.00
11.00	01100	CAFETERIA	0	0	0	13,278	11.00
13.00	01300	NURSING ADMINISTRATION	0	451	0	550	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,804	0	355	14.00
15.00	01500	PHARMACY	0	768	0	562	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	2,942	0	340	16.00
17.00	01700	SOCIAL SERVICE	0	80	0	234	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	767	17,190	217,431	2,316	30.00
31.00	03100	INTENSIVE CARE UNIT	1	1,021	0	158	31.00
43.00	04300	NURSERY	0	0	0	338	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	353	6,281	0	1,532	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	267	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	252	5,105	0	1,476	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	270	0	72	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	2,090	0	1,817	60.00
65.00	06500	RESPIRATORY THERAPY	17	362	0	417	65.00
66.00	06600	PHYSICAL THERAPY	4	2,815	0	776	66.00
67.00	06700	OCCUPATIONAL THERAPY	36	0	0	464	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	178	68.00
69.00	06900	ELECTROCARDIOLOGY	0	258	0	268	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	0	257	0	36	76.01
76.03	03953	WOUND CARE	63	0	0	99	76.03
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	449	2,173	0	1,023	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)	1,942	46,348	217,431	13,278	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	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 CIRCLE	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	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,942	46,348	217,431	13,278	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			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-MVBLE 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	RADIOISOTOPE	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	GIFT, 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 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)	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	
			25.00	26.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.01	01160	COMMUNICATIONS			5.01
5.02	00540	ADMINISTRATIVE			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			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	GIFT, 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 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		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)	COMMUNICATIONS (NONPATIENT PHONES)	Reconciliation	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
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	COMMUNICATIONS	448	448	95,250	659		5.01
5.02	00540	ADMINITTING	827	827	484,794	11	-730,519	5.02
5.03	00550	CASHIERING/ACCOUNTS RECEIVABLE	1,143	1,143	0	8	0	5.03
5.04	00560	OTHER ADMINISTRATIVE AND GENERAL	19,523	19,523	745,024	52	0	5.04
7.00	00700	OPERATION OF PLANT	71,895	71,895	294,217	12	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	1	0	8.00
9.00	00900	HOUSEKEEPING	928	928	325,374	2	0	9.00
10.00	01000	DIETARY	5,275	5,275	193	9	0	10.00
11.00	01100	CAFETERIA	0	0	761	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	958	958	867,449	3	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,835	3,835	163,588	5	0	14.00
15.00	01500	PHARMACY	1,632	1,632	582,668	11	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	6,256	6,256	185,734	25	0	16.00
17.00	01700	SOCIAL SERVICE	170	170	183,872	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	36,553	36,553	1,850,192	20	0	30.00
31.00	03100	INTENSIVE CARE UNIT	2,171	2,171	145,971	5	0	31.00
43.00	04300	NURSERY	0	0	300,121	1	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	13,355	13,355	1,275,887	34	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	237,584	2	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,855	10,855	1,080,934	21	0	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	575	575	45,595	2	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	4,444	4,444	1,005,271	19	0	60.00
65.00	06500	RESPIRATORY THERAPY	769	769	324,876	3	0	65.00
66.00	06600	PHYSICAL THERAPY	5,985	5,985	540,403	5	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	312,892	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	151,110	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	548	548	189,775	6	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	546	546	32,391	0	0	76.01
76.03	03953	WOUND CARE	0	0	63,740	0	0	76.03
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	4,620	4,620	912,223	17	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)	194,042	194,042	12,397,889	274	-730,519	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	4	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	381	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						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 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)	COMMUNICATIONS (NONPATIENT PHONES)	Reconciliation	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
			1.00	2.00	4.00	5.01	5A.02	
205.00		Unit cost multiplier (Wkst. B, Part II)			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

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

Cost Center Description		ADMINISTRATIVE (ACCUM. COST)	Reconciliation	CASHIERING/ACCOUNTS RECEIVABLE (ACCUM. COST)	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	
		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-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	01160	COMMUNICATIONS					5.01
5.02	00540	ADMINISTRATIVE	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	5.04
7.00	00700	OPERATION OF PLANT	3,785,441	0	3,862,743	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	114,083	0	116,413	0	8.00
9.00	00900	HOUSEKEEPING	534,395	0	545,308	0	9.00
10.00	01000	DIETARY	313,933	0	320,344	0	10.00
11.00	01100	CAFETERIA	786,152	0	802,206	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,189,458	0	1,213,748	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	519,447	0	530,055	0	14.00
15.00	01500	PHARMACY	915,470	0	934,165	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	677,199	0	691,028	0	16.00
17.00	01700	SOCIAL SERVICE	303,149	0	309,340	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	4,172,894	0	4,258,109	0	30.00
31.00	03100	INTENSIVE CARE UNIT	530,237	0	541,065	0	31.00
43.00	04300	NURSERY	652,040	0	665,355	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	3,275,165	0	3,342,047	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	516,955	0	527,512	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,768,874	0	1,804,996	0	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	139,316	0	142,161	0	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	2,481,469	0	2,532,143	0	60.00
65.00	06500	RESPIRATORY THERAPY	466,663	0	476,193	0	65.00
66.00	06600	PHYSICAL THERAPY	855,772	0	873,248	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	404,764	0	413,030	0	67.00
68.00	06800	SPEECH PATHOLOGY	195,831	0	199,830	0	68.00
69.00	06900	ELECTROCARDIOLOGY	273,389	0	278,972	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	102,062	0	104,146	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	253,023	0	258,190	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,139,765	0	1,163,040	0	73.00
76.00	03950	OTHER ANCILLARY	0	0	0	0	76.00
76.01	03951	SLEEP LAB	63,822	0	65,125	0	76.01
76.03	03953	WOUND CARE	92,221	0	94,104	0	76.03
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	2,250,550	0	2,296,508	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	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	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,591	0	2,644	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	246,794	0	251,834	0	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 CIRCLE	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)	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 09/30/2022

Worksheet B-1

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

Cost Center Description			ADMINISTRATIVE (ACCUM. COST)	Reconciliation	CASHIERING/ACCOUNTS RECEIVABLE (ACCUM. COST)	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	
			5.02	5A.03	5.03	5A.04	5.04	
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		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	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	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	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	13,167	11.00
13.00	01300	NURSING ADMINISTRATION	958	0	958	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,835	0	3,835	0	14.00
15.00	01500	PHARMACY	1,632	0	1,632	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	6,256	0	6,256	0	16.00
17.00	01700	SOCIAL SERVICE	170	0	170	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	36,553	66,172	36,553	21,473	30.00
31.00	03100	INTENSIVE CARE UNIT	2,171	93	2,171	0	31.00
43.00	04300	NURSERY	0	0	0	0	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	30,429	13,355	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,855	21,685	10,855	0	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	575	0	575	0	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	0	4,444	0	60.00
65.00	06500	RESPIRATORY THERAPY	769	1,502	769	0	65.00
66.00	06600	PHYSICAL THERAPY	5,985	351	5,985	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	3,081	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	548	0	548	0	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	0	546	0	76.01
76.03	03953	WOUND CARE	0	5,416	0	0	76.03
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	4,620	38,699	4,620	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	95.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	99,475	167,428	98,547	21,473	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	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 CIRCLE	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)	4,761,033	143,485	716,537	685,665	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	47.861603	0.856995	7.271018	31.931495	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	1,694,954	1,942	46,348	217,431	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	17.038995	0.011599	0.470314	10.125786	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 09/30/2022

Worksheet 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)	
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)	7.00	8.00	9.00	10.00	11.00	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 REQUIS.)	PHARMACY (% COSTED REQUI)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TOTAL PATIENT DAYS)	
			13.00	14.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01160	COMMUNICATIONS						5.01
5.02	00540	ADMINISTRATIVE						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	RADIOLOGY-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	RADIOISOTOPE	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 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						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 II)	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 09/30/2022

Worksheet B-1

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

Cost Center Description		NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (% COSTED R EQUI)	MEDICAL RECORDS & LIBRARY (GROSS CHAR GES)	SOCIAL SERVICE (TOTAL PATI ENT DAYS)	
		(FTES IN NU RSING ARE)					
206.00		13.00	14.00	15.00	16.00	17.00	206.00
207.00	NAHE adjustment amount to be allocated (per Wkst. B-2) NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

Worksheet C
Part I
Date/Time Prepared:
2/28/2023 8:13 pm

MCRI F32 - 17.13.175.6

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

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

			Title XIX		Hospital		Cost	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
					Total Costs	RCE Disallowance		Total Costs
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	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	0	693,299	0	693,299	65.00
66.00	06600	PHYSICAL THERAPY	1,495,392	0	1,495,392	0	1,495,392	66.00
67.00	06700	OCCUPATIONAL THERAPY	568,131	0	568,131	0	568,131	67.00
68.00	06800	SPEECH PATHOLOGY	266,970	0	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		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	0	37,635,581	0	37,635,581	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	36,189,130	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

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

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	30.00
31.00	INTENSIVE CARE UNIT		99,611		99,611	96	1,037.61	31.00
43.00	NURSERY		14,326		14,326	427	33.55	43.00
44.00	SKILLED NURSING FACILITY		0		0	0	0.00	44.00
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				
31.00	INTENSIVE CARE UNIT		32	33,204				
43.00	NURSERY		0	0				
44.00	SKILLED NURSING FACILITY		0	0				
200.00	Total (lines 30 through 199)		875	443,087				

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

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	
					Title XVIII		Hospital		PPS	
Cost Center Description			Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost			
			1A	1.00	2A	2.00	3.00			
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00		
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00		
43.00	04300	NURSERY	0	0	0	0	0	43.00		
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00		
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00		
Cost Center Description			Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days			
			4.00	5.00	6.00	7.00	8.00			
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0	0	3,765	0.00	843	30.00		
31.00	03100	INTENSIVE CARE UNIT		0	96	0.00	32	31.00		
43.00	04300	NURSERY		0	427	0.00	0	43.00		
44.00	04400	SKILLED NURSING FACILITY		0	0	0.00	0	44.00		
200.00		Total (lines 30 through 199)		0	4,288		875	200.00		
Cost Center Description			Inpatient Program Pass-Through Cost (col. 7 x col. 8)							
			9.00							
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0						30.00	
31.00	03100	INTENSIVE CARE UNIT	0						31.00	
43.00	04300	NURSERY	0						43.00	
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			Title XVIII			Hospital		PPS
			Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
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	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			Title XVIII		Hospital	PPS		
			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)		Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	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						95.00
200.00		Total (lines 50 through 199)	0	0	0	201,078,107		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

				Title XVIII		Hospital	PPS	
Cost Center Description			Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.000000	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	ULTRASOUND	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

			Title XVIII		Hospital		PPS		
Cost Center Description			Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs			
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
			1.00	2.00	3.00	4.00	5.00		
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.172891	5,528,326	0	0	955,798	50.00	
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.937697	0	0	0	0	52.00	
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.078655	6,958,282	0	0	547,304	54.00	
54.01	03630	ULTRASOUND	0.000000	0	0	0	0	54.01	
56.00	05600	RADIOISOTOPE	0.180687	324,037	0	0	58,549	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	0.085232	2,455,507	4,293	0	209,288	60.00	
65.00	06500	RESPIRATORY THERAPY	0.201664	71,482	0	0	14,415	65.00	
66.00	06600	PHYSICAL THERAPY	0.333547	4,922	0	0	1,642	66.00	
67.00	06700	OCCUPATIONAL THERAPY	0.157009	861	0	0	135	67.00	
68.00	06800	SPEECH PATHOLOGY	0.216687	0	0	0	0	68.00	
69.00	06900	ELECTROCARDIOLOGY	0.065575	1,959,780	0	0	128,513	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.024212	606,606	0	0	14,687	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.124044	757,693	0	0	93,987	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0.173836	4,843,963	0	16,220	842,055	73.00	
76.00	03950	OTHER ANCILLARY	0.000000	0	0	0	0	76.00	
76.01	03951	SLEEP LAB	0.275448	57,791	0	0	15,918	76.01	
76.03	03953	WOUND CARE	0.390013	194,861	0	0	75,998	76.03	
	OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.005703	39,907	0	0	228	90.00	
91.00	09100	EMERGENCY	0.160462	2,614,403	0	0	419,512	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.696668	275,658	0	0	192,042	92.00	
	OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0.000000		0			95.00	
200.00		Subtotal (see instructions)		26,694,079	4,293	16,220	3,570,071	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	

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
			Title XVIII		Hospital	PPS
Cost Center Description			Costs			
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
ANCILLARY SERVICE COST CENTERS						
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	RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.01	03630	ULTRA SOUND	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	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	IMPL. 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

			Title XIX		Hospital		Cost	
Cost Center Description			Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs		
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.172891	0	0	189,240	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.937697	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.078655	0	0	393,770	0	54.00
54.01	03630	ULTRA SOUND	0.000000	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.180687	0	0	15,414	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	0.085232	0	0	389,994	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.201664	0	0	6,635	0	65.00
66.00	06600	PHYSICAL THERAPY	0.333547	0	0	286,907	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.157009	0	0	492,081	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.216687	0	0	184,210	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.065575	0	0	27,529	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.024212	0	0	20,817	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.124044	0	0	42,354	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.173836	0	0	58,813	0	73.00
76.00	03950	OTHER ANCILLARY	0.000000	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0.275448	0	0	0	0	76.01
76.03	03953	WOUND CARE	0.390013	0	0	2,570	0	76.03
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.005703	0	0	1,835	0	90.00
91.00	09100	EMERGENCY	0.160462	0	0	432,950	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.696668	0	0	65,120	0	92.00
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	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	0	2,610,239	0	202.00

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	
				Title XIX		Hospital		Cost	
Cost Center Description			Costs						
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)					
			6.00	7.00					
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	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	RADIOLOGY-DIAGNOSTIC	0	30,972					54.00
54.01	03630	ULTRA SOUND	0	0					54.01
56.00	05600	RADIOISOTOPE	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	IMPL. 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 Only Charges	0						201.00
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 09/30/2022	Worksheet 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 09/30/2022

Worksheet D-1

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

Cost Center Description		Title XVIII			Hospital		PPS	
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
		1.00	2.00	3.00	4.00	5.00		
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0		42.00
	Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	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 09/30/2022

Worksheet D-1

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

Cost Center Description		Title XVIII		Hospital		PPS	
		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	1,830,630	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 09/30/2022	Worksheet 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	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		2,303,335	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	50.00
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	54.00
54.01	03630	ULTRA SOUND	0.000000	0	54.01
56.00	05600	RADIOISOTOPE	0.180687	18,203	56.00
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	60.00
65.00	06500	RESPIRATORY THERAPY	0.201664	834,197	65.00
66.00	06600	PHYSICAL THERAPY	0.333547	186,194	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.157009	114,546	67.00
68.00	06800	SPEECH PATHOLOGY	0.216687	15,626	68.00
69.00	06900	ELECTROCARDIOLOGY	0.065575	338,385	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.024212	764,991	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.124044	150,427	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.173836	923,686	73.00
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	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.696668	130,724	92.00
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 Component CCN: 15-U075	Period: From 10/01/2021 To 09/30/2022	Worksheet D-3 Date/Time Prepared: 2/28/2023 8:13 pm	
Cost Center Description			Title XVIII	Swing Beds - SNF	PPS	
			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
43.00	04300	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.172891	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.937697	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.078655	17,958	1,412	54.00
54.01	03630	ULTRA SOUND	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0.180687	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MRI	0.000000	0	0	58.00
60.00	06000	LABORATORY	0.085232	160,564	13,685	60.00
65.00	06500	RESPIRATORY THERAPY	0.201664	429,450	86,605	65.00
66.00	06600	PHYSICAL THERAPY	0.333547	545,551	181,967	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.157009	417,036	65,478	67.00
68.00	06800	SPEECH PATHOLOGY	0.216687	30,343	6,575	68.00
69.00	06900	ELECTROCARDIOLOGY	0.065575	5,884	386	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.024212	278,582	6,745	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.124044	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.173836	303,061	52,683	73.00
76.00	03950	OTHER ANCILLARY	0.000000	0	0	76.00
76.01	03951	SLEEP LAB	0.275448	0	0	76.01
76.03	03953	WOUND CARE	0.390013	1,606	626	76.03
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.005703	0	0	90.00
91.00	09100	EMERGENCY	0.160462	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.696668	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		2,190,035	416,162	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)		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: 2/28/2023 8:13 pm	
Cost Center Description		Title XIX	Hospital	Cost	
		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	148,446	25,665	50.00
51.00	05100	RECOVERY ROOM	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	14,653	13,740	52.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	24,514	1,928	54.00
54.01	03630	ULTRA SOUND	0	0	54.01
56.00	05600	RADIOISOTOPE	5,716	1,033	56.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MRI	0	0	58.00
60.00	06000	LABORATORY	111,986	9,545	60.00
65.00	06500	RESPIRATORY THERAPY	23,425	4,724	65.00
66.00	06600	PHYSICAL THERAPY	6,198	2,067	66.00
67.00	06700	OCCUPATIONAL THERAPY	944	148	67.00
68.00	06800	SPEECH PATHOLOGY	361	78	68.00
69.00	06900	ELECTROCARDIOLOGY	18,611	1,220	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	75,449	1,827	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	48,539	8,438	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	1,113	6	90.00
91.00	09100	EMERGENCY	44,361	7,118	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	8,200	5,713	92.00
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	83,250	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 09/30/2022	Worksheet E Part A Date/Time Prepared: 2/28/2023 8:13 pm
		Title XVIII	Hospital	PPS
		1.00		
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
1.00	DRG Amounts Other than Outlier Payments		0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		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 09/30/2022	Worksheet 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	
Uncompensated Care Adjustment					
35.00	Total uncompensated care amount (see instructions)		0	7,192,008,710	35.00
35.01	Factor 3 (see instructions)	0.000000000	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
Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)					
40.00	Total Medicare discharges (see instructions)		0		40.00
			Before 1/1	On/After 1/1	
			1.00	1.01	
41.00	Total ESRD Medicare discharges (see instructions)		0	0	41.00
41.01	Total ESRD Medicare covered and paid discharges (see instructions)		0	0	41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00			42.00
43.00	Total Medicare ESRD inpatient days (see instructions)		0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000			44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00		0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)		0		46.00
47.00	Subtotal (see instructions)		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)				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 09/30/2022	Worksheet E Part A Date/Time Prepared: 2/28/2023 8:13 pm
		Title XVIII	Hospital	PPS
		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0		0 70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	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			71.03
72.00	Interim payments		2,445,577	72.00
72.01	Interim payments-PARHM			72.01
73.00	Tentative settlement (for contractor use only)		0	73.00
73.01	Tentative settlement-PARHM (for contractor use only)			73.01
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		91,035	74.00
74.01	Balance due provider/program-PARHM (see instructions)			74.01
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		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	1.00	2.00	3.00	4.00	5.00
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	0	0	0	0	0
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	1,921,369	0	0	1,921,369	1,921,369
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0	0	0
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0	0	0	0
2.00	Outlier payments for discharges (see instructions)	2.00					
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	0	0	0	0	0
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	20,399	0	0	20,399	20,399
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0
4.00	Managed care simulated payments	3.00	2,166,243	0	0	2,166,243	2,166,243
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
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0
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
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1078	0.1078	0.1078	0.1078	0
11.00	Disproportionate share adjustment (see instructions)	34.00	51,781	0	0	51,781	51,781
11.01	Uncompensated care payments	36.00	182,778	0	0	182,778	182,778
Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0
13.00	Subtotal (see instructions)	47.00	2,176,327	0	0	2,176,327	2,176,327
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0
15.00	Total payment for inpatient operating costs (see instructions)	49.00	2,176,327	0	0	2,176,327	2,176,327
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	147,635	0	0	147,635	147,635

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	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 09/30/2022	Worksheet 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				
Reasonable charges				
12.00	Ancillary service 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

CALCULATION OF REIMBURSEMENT SETTLEMENT	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
MEDICARE PART B ANCILLARY COSTS			
200.00 Part B Combined Billed Days			0 200.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-0075

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	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00	
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01	
3.02			0		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50	
3.51			0		0	3.51	
3.52			0		0	3.52	
3.53			0		0	3.53	
3.54			0		0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2,445,577		2,050,691	4.00	
TO BE COMPLETED BY CONTRACTOR							
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00	
Program to Provider							
5.01	TENTATIVE TO PROVIDER		0		0	5.01	
5.02			0		0	5.02	
5.03			0		0	5.03	
Provider to Program							
5.50	TENTATIVE TO PROGRAM		0		0	5.50	
5.51			0		0	5.51	
5.52			0		0	5.52	
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99	
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00	
6.01	SETTLEMENT TO PROVIDER		91,035		21,671	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		2,536,612		2,072,362	7.00	
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor					8.00	

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-0075

Period:

Worksheet E-1

Component CCN: 15-U075

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

		Title XVIII		Swing Beds - SNF		PPS
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		504,492		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		504,492		0	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		504,492		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

Provider CCN: 15-0075

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

Period:

Worksheet E-2

Component CCN: 15-U075

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

		Title XVIII	Swing Beds - SNF	PPS	
			Part A	Part B	
			1.00	2.00	
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient routine services - swing bed-SNF (see instructions)		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)				16.50
16.55	Rural community hospital demonstration project (\$410A Demonstration) payment adjustment (see instructions)		0		16.55
16.99	Demonstration payment adjustment amount before sequestration		0	0	16.99
17.00	Allowable bad debts (see instructions)		0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)		0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	0	18.00
19.00	Total (see instructions)		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				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				20.01
21.00	Tentative settlement (for contractor use only)		0	0	21.00
21.01	Tentative settlement-PARHM (for contractor use only)				21.01
22.00	Balance due provider/program (line 19 minus lines 19.01, 19.02, 19.25, 20, and 21)		0	0	22.00
22.01	Balance due provider/program-PARHM (see instructions)				22.01
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	0	23.00
Rural Community Hospital Demonstration Project (\$410A Demonstration) Adjustment					
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.				200.00
Cost Reimbursement					
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))				201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))				202.00
203.00	Total (sum of lines 201 and 202)				203.00
204.00	Medicare swing-bed SNF discharges (see instructions)				204.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)					
205.00	Medicare swing-bed SNF target amount				205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)				206.00
Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement					
207.00	Program reimbursement under the \$410A Demonstration (see instructions)				207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)				208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)				209.00
210.00	Reserved for future use				210.00
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	4.00	
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	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 depreciable	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	0	53.00
54.00	Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00	Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00	Governing body created - endowment fund balance	0	0	0	0	56.00
57.00	Plant fund balance - invested in plant	0	0	0	0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	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 09/30/2022

Worksheet 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				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		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		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)						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 09/30/2022Worksheet 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	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY	0		0	7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	12,566,267		12,566,267	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	583,721		583,721	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	583,721		583,721	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	13,149,988		13,149,988	17.00
18.00	Ancillary services	36,470,156	139,495,817	175,965,973	18.00
19.00	Outpatient services	3,336,035	21,771,879	25,107,914	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	0	0	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	IP CONTRACTED HOSPICE	21,910	0	21,910	27.00
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	28.00
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 09/30/2022

Worksheet 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 09/30/2022Worksheet 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