

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: 15-0009	Period: From 08/01/2021 To 07/31/2022	Worksheet S Parts I-III Date/Time Prepared: 12/22/2022 2:33 pm
---	-----------------------	---	---

PART I - COST REPORT STATUS

Provider 1. [X] Electronically prepared cost report Date: 12/22/2022 Time: 2:33 pm
use only 2. [] Manually prepared cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

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

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

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by CLARK MEMORIAL HOSPITAL (15-0009) for the cost reporting period beginning 08/01/2021 and ending 07/31/2022 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR	CHECKBOX	ELECTRONIC SIGNATURE STATEMENT		1
			1	2	
1	<i>Jason Schmiedt</i>	Y	I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.		1
2	Signatory Printed Name	Jason Schmiedt			2
3	Signatory Title	CFO			3
4	Date	(Dated when report is electronic)			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	321,031	-151,481	0	0	1.00
2.00 Subprovider - IPF	0	-225	0	0	0	2.00
3.00 Subprovider - IRF	0	0	0	0	0	3.00
4.00 SUBPROVIDER I						4.00
5.00 Swing Bed - SNF	0	0	0	0	0	5.00
6.00 Swing Bed - NF	0	0	0	0	0	6.00
7.00 SKILLED NURSING FACILITY	0	0	0	0	0	7.00
200.00 Total	0	320,806	-151,481	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.

	1.00	2.00	3.00	4.00						
Hospital and Hospital Health Care Complex Address:										
1.00	Street: 1220 MISSOURI AVENUE	PO Box: 69	zip Code: 47130	County: CLARK	1.00					
2.00	City: JEFFERSONVILLE	State: IN			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:						From:	To:			
3.00	Hospital	CLARK MEMORIAL HOSPITAL	150009	31140	1	07/01/1966	N	P	O	3.00
4.00	Subprovider - IPF	BEHAVIORAL MEDICINE UNIT	15S009	31140	4	01/01/1992	N	P	P	4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	other									19.00
20.00	Cost Reporting Period (mm/dd/yyyy)					From:	To:			
21.00	Type of Control (see instructions)					1.00	2.00			
						08/01/2021	07/31/2022	20.00	21.00	
						4				
							1.00	2.00	3.00	
Inpatient PPS Information						From:	To:			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					Y	N			22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					Y	Y			22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N			22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N	N		22.03
22.04	Did this hospital receive a geographic reclassification from urban to rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N	N		22.04
23.00	which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					3	N			23.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 15-0009		Period: From 08/01/2021 To 07/31/2022	Worksheet S-2 Part I Date/Time Prepared: 12/22/2022 2:33 pm			
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days			
		1.00	2.00	3.00	4.00	5.00	6.00			
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	0	1,526	0	105	9,859	26	24.00		
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00		
							Urban/Rural S	Date of Geogr		
							1.00	2.00		
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					1		26.00		
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					1		27.00		
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0		35.00		
							Beginning:	Ending:		
							1.00	2.00		
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.							36.00		
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					0		37.00		
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)							37.01		
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.							38.00		
							Y/N	Y/N		
							1.00	2.00		
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					N	N	39.00		
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					N	Y	40.00		
							V	XVIII	XIX	
							1.00	2.00	3.00	
Prospective Payment System (PPS)-Capital										
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)					N	Y	N	45.00	
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					N	N	N	46.00	
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.					N	N	N	47.00	
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N	48.00	
Teaching Hospitals										
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2.					Y	Y		56.00	
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.					N			57.00	
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.					N			58.00	
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N			59.00	

			NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
			1.00	2.00	3.00	
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.	N			60.00	
			Y/N	IME	Direct GME	
			1.00	2.00	3.00	4.00
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N		0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)					61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)					61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)					61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).					61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)					61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)					61.06
			Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count
			1.00	2.00	3.00	4.00
61.10	of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0.00	0.00	61.10
61.20	of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0.00	0.00	61.20
					1.00	
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)						
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)				0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during this cost reporting period of HRSA THC program. (see instructions)				0.00	62.01
Teaching Hospitals that Claim Residents in Nonprovider Settings						
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)			N		63.00
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
			1.00	2.00	3.00	
Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.						
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	64.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA			Provider CCN: 15-0009	Period: From 08/01/2021 To 07/31/2022	Worksheet S-2 Part I Date/Time Prepared: 12/22/2022 2:33 pm				
	Program Name	Program Code	Unweighted FTES Nonprovider Site	Unweighted FTES in Hospital	Ratio (col. 3/ (col. 3 + col. 4))				
	1.00	2.00	3.00	4.00	5.00				
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00		
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)			Unweighted FTES Nonprovider Site	Unweighted FTES in Hospital	Ratio (col. 1/ (col. 1 + col. 2))			
			1.00	2.00	3.00				
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		
	Program Name	Program Code	Unweighted FTES Nonprovider Site	Unweighted FTES in Hospital	Ratio (col. 3/ (col. 3 + col. 4))				
	1.00	2.00	3.00	4.00	5.00				
						1.00	2.00	3.00	
	Inpatient Psychiatric Facility PPS 70.00 Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.					Y	N	0	70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)					N	N	0	71.00
	Inpatient Rehabilitation Facility PPS 75.00 Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.					N		0	75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)							0	76.00

1.00

Long Term Care Hospital PPS			
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.		N 80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.		N 81.00
TEFRA Providers			
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.		N 85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.		N 86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.		N 87.00
		V 1.00	XIX 2.00
Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y 90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	Y 91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N 92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N 93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N 94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00 95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N 96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00 97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y 98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y 98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y 98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N 98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N 98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y 98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y 98.06
Rural Providers			
105.00	Does this hospital qualify as a CAH?	N	105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N	106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&R in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N	107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N	108.00
	Physical 1.00	Occupational 2.00	Speech 3.00
			Respiratory 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	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

	1.00	2.00	111.00
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.			
	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.	N		116.00
117.00 Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N		117.00
118.00 Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1		118.00
	Premiums	Losses	Insurance
	1.00	2.00	3.00
118.01 List amounts of malpractice premiums and paid losses:	1,162,914	0	0118.01
	1.00	2.00	
118.02 Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00 DO NOT USE THIS LINE			
120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	119.00 120.00
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	HB0616	140.00

	1.00	2.00	3.00			
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.						
141.00 Name: LIFEPOINT HEALTH, INC.	Contractor's Name: PALMETTO GBA	Contractor's Number: 10001	141.00			
142.00 Street: 330 SEVEN SPRINGS WAY	PO Box:		142.00			
143.00 City: BRENTWOOD	State: TN	Zip Code: 37027	143.00			
1.00						
144.00 Are provider based physicians' costs included in Worksheet A?	Y			144.00		
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.	Y			145.00		
146.00 Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N			146.00		
1.00						
147.00 Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	N			147.00		
148.00 Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	N			148.00		
149.00 Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.	N			149.00		
	Part A	Part B	Title V	Title XIX		
	1.00	2.00	3.00	4.00		
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)						
155.00 Hospital	N	N	N	N	155.00	
156.00 Subprovider - IPF	N	N	N	N	156.00	
157.00 Subprovider - IRF	N	N	N	N	157.00	
158.00 SUBPROVIDER					158.00	
159.00 SNF	N	N	N	N	159.00	
160.00 HOME HEALTH AGENCY	N	N	N	N	160.00	
161.00 CMHC		N	N	N	161.00	
1.00						
Multicampus						
165.00 Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.	N			165.00		
	Name	County	State	CBSA	FTE/Campus	
	0	1.00	2.00	3.00	4.00	
166.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)					0.00	166.00
1.00						
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act						
167.00 Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	Y			167.00		
168.00 If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	168.00					
168.01 If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)	168.01					
169.00 If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	9.99			169.00		
	Beginning	Ending				
	1.00	2.00				
170.00 Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)				170.00		
	1.00	2.00				
171.00 If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N			0171.00		

		Y/N	Date	
		1.00	2.00	
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
COMPLETED BY ALL HOSPITALS				
Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00
		Y/N	Date	V/I
		1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y		3.00
		Y/N	Type	Date
		1.00	2.00	3.00
Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	12/31/2022
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 the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing programs and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	Y		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	Y		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00
		Y/N		
		1.00		
Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y		12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N		13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N		14.00
Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N		15.00
		Part A	Part B	
		Y/N	Date	
		1.00	2.00	
		Y/N	Date	
		1.00	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	10/27/2022	Y
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
		10/27/2022		10/27/2022

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

COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)**Capital Related Cost**

22.00	Have assets been relieved for Medicare purposes? If yes, see instructions	N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.	N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions	N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.	N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.	N	27.00

Interest Expense

28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.	N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions	N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	N	31.00

Purchased Services

32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.	N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.	N	33.00

Provider-Based Physicians

34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.	Y	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.	Y	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	12/31/2022
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.	DANA	AYLWARD	41.00
42.00	Enter the employer/company name of the cost report preparer.	LIFEPOINT HEALTH, INC.		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	203-260-7881	DANA.AYLWARD@LPNT.NET	43.00

	3.00		
Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	REIMBURSEMENT 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

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	128	46,720	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)		128	46,720	0.00		0	7.00		
8.00	INTENSIVE CARE UNIT	31.00	22	8,030	0.00		0	8.00		
9.00	CORONARY CARE UNIT	32.00	0	0	0.00		0	9.00		
9.01	NEONATAL INTENSIVE CARE UNIT	32.01	3	1,095	0.00		0	9.01		
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)		153	55,845	0.00		0	14.00		
15.00	CAH visits									0 15.00
16.00	SUBPROVIDER - IPF	40.00	15	5,475			0	16.00		
17.00	SUBPROVIDER - IRF	41.00	0	0			0	17.00		
18.00	SUBPROVIDER	42.00	0	0			0	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)			168						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)									32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)		0	0						32.01
33.00	LTCH non-covered days									33.00
33.01	LTCH site neutral days and discharges									33.01

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents	
	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll
	6.00	7.00	8.00	9.00	10.00
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	9,524	1,071	29,210		1.00
2.00 HMO and other (see instructions)	8,625	10,026			2.00
3.00 HMO IPF Subprovider	1,421	28			3.00
4.00 HMO IRF Subprovider	0	0			4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	0	0	0		5.00
6.00 Hospital Adults & Peds. Swing Bed NF		0	0		6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	9,524	1,071	29,210		7.00
8.00 INTENSIVE CARE UNIT	1,022	140	6,911		8.00
9.00 CORONARY CARE UNIT	0	0	0		9.00
9.01 NEONATAL INTENSIVE CARE UNIT	0	100	898		9.01
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		153	2,047		13.00
14.00 Total (see instructions)	10,546	1,464	39,066	0.68	905.80
15.00 CAH visits	0	0	0		15.00
16.00 SUBPROVIDER - IPF	866	64	1,850	0.00	13.70
17.00 SUBPROVIDER - IRF	0	0	0	0.00	17.00
18.00 SUBPROVIDER		0	0	0.00	18.00
19.00 SKILLED NURSING FACILITY	0	0	0	0.00	19.00
20.00 NURSING FACILITY					20.00
21.00 OTHER LONG TERM CARE					21.00
22.00 HOME HEALTH AGENCY					22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)					23.00
24.00 HOSPICE					24.00
24.10 HOSPICE (non-distinct part)			157		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
27.00 Total (sum of lines 14-26)				0.68	26.25
28.00 Observation Bed Days		77	2,590		27.00
29.00 Ambulance Trips	0				28.00
30.00 Employee discount days (see instruction)			77		29.00
31.00 Employee discount days - IRF			0		30.00
32.00 Labor & delivery days (see instructions)	0	26	54		31.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)			0		32.00
33.00 LTCH non-covered days	0				32.01
33.01 LTCH site neutral days and discharges	0				33.00
					33.01

Component	Full Time Equivalents	Discharges			Total All Patients	
		Nonpaid Workers	Title V	Title XVIII		
		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	2,305	310	7,520 1.00
2.00 HMO and other (see instructions)				1,595	1,852	2.00
3.00 HMO IPF Subprovider					6	3.00
4.00 HMO IRF Subprovider					0	4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
9.01 NEONATAL INTENSIVE CARE UNIT						9.01
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	2,305	310	7,520	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF	0.00	0	198	10	228	16.00
17.00 SUBPROVIDER - IRF	0.00	0	0	0	0	17.00
18.00 SUBPROVIDER	0.00	0		0	0	18.00
19.00 SKILLED NURSING FACILITY	0.00					19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days				0		33.00
33.01 LTCH site neutral days and discharges				0		33.01

	Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)								
							1.00	2.00						
PART II - WAGE DATA														
SALARIES														
1.00	Total salaries (see instructions)	200.00	76,252,542	65,265	76,317,807	1,912,572.68	39.90	1.00						
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00						
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00						
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00						
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01						
5.00	Physician-Part B		0	0	0	0.00	0.00	5.00						
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00	6.00						
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00						
7.01	Contracted interns and residents (in an approved programs)		0	51,640	51,640	1,992.00	25.92	7.01						
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00	8.00						
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00						
10.00	Excluded area salaries (see instructions)		19,372,366	88,097	19,460,463	387,464.67	50.23	10.00						
OTHER WAGES & RELATED COSTS														
11.00	Contract labor: Direct Patient Care		19,380,644	0	19,380,644	205,926.00	94.11	11.00						
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00						
13.00	Contract labor: Physician-Part A - Administrative		646,003	0	646,003	5,904.78	109.40	13.00						
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00	14.00						
14.01	Home office salaries		2,391,507	0	2,391,507	24,393.23	98.04	14.01						
14.02	Related organization salaries		0	0	0	0.00	0.00	14.02						
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00						
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00						
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00	16.01						
16.02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.02						
WAGE-RELATED COSTS														
17.00	wage-related costs (core) (see instructions)		10,564,476	0	10,564,476			17.00						
18.00	wage-related costs (other) (see instructions)							18.00						
19.00	Excluded areas		2,683,981	0	2,683,981			19.00						
20.00	Non-physician anesthetist Part A		0	0	0			20.00						
21.00	Non-physician anesthetist Part B		0	0	0			21.00						
22.00	Physician Part A - Administrative		0	0	0			22.00						
22.01	Physician Part A - Teaching		0	0	0			22.01						
23.00	Physician Part B		0	0	0			23.00						
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00						
25.00	Interns & residents (in an approved program)		0	0	0			25.00						
25.50	Home office wage-related (core)		2,513,953	0	2,513,953			25.50						
25.51	Related organization wage-related (core)		0	0	0			25.51						
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0			25.52						

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0009

Period:
From 08/01/2021
To 07/31/2022Worksheet S-3
Part II
Date/Time Prepared:
12/22/2022 2:33 pm

	Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
1.00	2.00	3.00	4.00	5.00	6.00		
25.53	Home office: Physicians Part A - Teaching - wage-related (core)		0	0	0		25.53
OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	772,574	2,855	775,429	20,944.04	37.02
27.00	Administrative & General	5.00	8,431,343	-421,315	8,010,028	279,923.64	28.62
28.00	Administrative & General under contract (see inst.)		473,706	0	473,706	2,764.78	171.34
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00
30.00	Operation of Plant	7.00	891,701	0	891,701	33,620.27	26.52
31.00	Laundry & Linen Service	8.00	87,493	207	87,700	5,989.50	14.64
32.00	Housekeeping	9.00	1,663	0	1,663	71.00	23.42
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00
34.00	Dietary	10.00	1,030,045	-562,787	467,258	23,143.61	20.19
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00
36.00	Cafeteria	11.00	0	562,787	562,787	28,930.34	19.45
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00
38.00	Nursing Administration	13.00	852,395	268,041	1,120,436	20,569.04	54.47
39.00	Central Services and Supply	14.00	275,908	0	275,908	14,182.44	19.45
40.00	Pharmacy	15.00	2,507,415	22,185	2,529,600	60,419.88	41.87
41.00	Medical Records & Medical Records Library	16.00	644,455	-51,047	593,408	27,286.13	21.75
42.00	Social Service	17.00	1,202,000	0	1,202,000	33,292.75	36.10
43.00	other General Service	18.00	0	0	0	0.00	0.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0009

Period:
From 08/01/2021
To 07/31/2022Worksheet S-3
Part III
Date/Time Prepared:
12/22/2022 2:33 pm

	Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)		
							1.00	2.00
PART III - HOSPITAL WAGE INDEX SUMMARY								
1.00	Net salaries (see instructions)	76,726,248	13,625	76,739,873	1,913,345.46	40.11	1.00	
2.00	Excluded area salaries (see instructions)	19,372,366	88,097	19,460,463	387,464.67	50.23	2.00	
3.00	Subtotal salaries (line 1 minus line 2)	57,353,882	-74,472	57,279,410	1,525,880.79	37.54	3.00	
4.00	Subtotal other wages & related costs (see inst.)	22,418,154	0	22,418,154	236,224.01	94.90	4.00	
5.00	Subtotal wage-related costs (see inst.)	13,078,429	0	13,078,429	0.00	22.83	5.00	
6.00	Total (sum of lines 3 thru 5)	92,850,465	-74,472	92,775,993	1,762,104.80	52.65	6.00	
7.00	Total overhead cost (see instructions)	17,170,698	-179,074	16,991,624	551,137.42	30.83	7.00	

		Amount Reported	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	500,558	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)	6,899,465	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	0	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	59,953	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	0	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	0	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	362,724	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	5,148,984	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	64,023	19.00
20.00	State or Federal Unemployment Taxes	58,181	20.00
OTHER			
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	103,814	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	32,998	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	13,230,700	24.00
Part B - Other than Core Related Cost			
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 15-0009

Period:
From 08/01/2021
To 07/31/2022Worksheet S-3
Part V
Date/Time Prepared:
12/22/2022 2:33 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	19,380,644	13,230,700	1.00
2.00	Hospital	19,380,644	10,550,316	2.00
3.00	SUBPROVIDER - IPF	0	159,837	3.00
4.00	SUBPROVIDER - IRF	0	0	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	0	0	17.00
18.00	other	0	2,520,547	18.00

Period: From 08/01/2021 To 07/31/2022	Worksheet S-10
	Date/Time Prepared: 12/22/2022 2:33 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)	0.206888	1.00	
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid	41,012,136	2.00	
3.00	Did you receive DSH or supplemental payments from Medicaid?	N	3.00	
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		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	152,858,805	6.00	
7.00	Medicaid cost (line 1 times line 6)	31,624,652	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)	9,127,796	75,565	9,203,361
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	1,888,431	75,565	1,963,996
22.00	Payments received from patients for amounts previously written off as charity care	100	12,502	12,602
23.00	Cost of charity care (line 21 minus line 22)	1,888,331	63,063	1,951,394
			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)		12,587,186	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		218,652	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		336,388	27.01
28.00	Non-Medicare bad debt expense (see instructions)		12,250,798	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		2,652,279	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		4,603,673	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		4,603,673	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-0009

Period:
From 08/01/2021
To 07/31/2022Worksheet A
Date/Time Prepared:
12/22/2022 2:33 pm

Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
					1.00	2.00
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT		5,303,087	5,303,087	1,275,915	6,579,002
2.00 00200	CAP REL COSTS-MVBLE EQUIP	0	0	0	1,776,110	1,776,110
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	772,574	7,034,850	7,807,424	-161,162	7,646,262
5.01 00540	NONPATIENT TELEPHONES	257,070	600,644	857,714	869	858,583
5.02 00590	PURCHASING	549,952	7,253,782	7,803,734	-7,281,441	522,293
5.03 00570	ADMITTING	2,113,543	672,978	2,786,521	10,895	2,797,416
5.04 00580	CASHIERING/ACCOUNTS RECEIVABLE	0	3,834,485	3,834,485	-7,851	3,826,634
5.05 00591	OTHER A&G	5,510,778	31,321,193	36,831,971	-2,842,773	33,989,198
7.00 00700	OPERATION OF PLANT	891,701	3,520,586	4,412,287	-8,608	4,403,679
8.00 00800	LAUNDRY & LINEN SERVICE	87,493	763,931	851,424	-71,276	780,148
9.00 00900	HOUSEKEEPING	1,663	2,314,663	2,316,326	-5,929	2,310,397
10.00 01000	DIETARY	1,030,045	1,592,218	2,622,263	-1,446,922	1,175,341
11.00 01100	CAFETERIA	0	0	0	1,432,729	1,432,729
13.00 01300	NURSING ADMINISTRATION	852,395	616,928	1,469,323	312,760	1,782,083
14.00 01400	CENTRAL SERVICES & SUPPLY	275,908	323,510	599,418	919	600,337
15.00 01500	PHARMACY	2,507,415	5,721,607	8,229,022	-4,604,018	3,625,004
16.00 01600	MEDICAL RECORDS & LIBRARY	644,455	1,289,634	1,934,089	-56,276	1,877,813
17.00 01700	SOCIAL SERVICE	1,202,000	459,310	1,661,310	-6,621	1,654,689
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	51,640	51,640
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	10,341,326	8,958,863	19,300,189	2,587,266	21,887,455
31.00 03100	INTENSIVE CARE UNIT	2,973,894	4,845,195	7,819,089	-2,706,238	5,112,851
32.00 03200	CORONARY CARE UNIT	0	0	0	0	0
32.01 02060	NEONATAL INTENSIVE CARE UNIT	1,023,091	806,891	1,829,982	-371,706	1,458,276
40.00 04000	SUBPROVIDER - IPF	1,145,821	246,891	1,392,712	9,231	1,401,943
41.00 04100	SUBPROVIDER - IRF	0	0	0	0	0
42.00 04200	SUBPROVIDER	0	0	0	0	0
43.00 04300	NURSERY	404,291	168,572	572,863	-159,893	412,970
44.00 04400	SKILLED NURSING FACILITY	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	3,676,526	7,078,962	10,755,488	611,884	11,367,372
51.00 05100	RECOVERY ROOM	845,068	89,905	934,973	120,872	1,055,845
52.00 05200	DELIVERY ROOM & LABOR ROOM	1,799,466	284,536	2,084,002	-332,722	1,751,280
54.00 05400	RADIOLOGY-DIAGNOSTIC	5,391,072	4,391,008	9,782,080	-1,058,800	8,723,280
59.00 05900	CARDIAC CATHETERIZATION	1,794,845	269,946	2,064,791	-164,924	1,899,867
60.00 06000	LABORATORY	2,384,802	3,531,714	5,916,516	-1,619,026	4,297,490
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	0	454,792	454,792	894,016	1,348,808
64.00 06400	INTRAVENOUS THERAPY	56,629	183,476	240,105	547,467	787,572
65.00 06500	RESPIRATORY THERAPY	2,272,109	882,535	3,154,644	154,359	3,309,003
66.00 06600	PHYSICAL THERAPY	717,840	57,697	775,537	1,150	776,687
69.00 06900	ELECTROCARDIOLOGY	691,288	88,133	779,421	-83,918	695,503
70.00 07000	ELECTROENCEPHALOGRAPHY	115,978	24,709	140,687	40,923	181,610
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	7,491,795	7,491,795
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	5,574,987	5,574,987	899,930	6,474,917
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	6,026,282	6,026,282
74.00 07400	RENAL DIALYSIS	0	458,427	458,427	0	458,427
76.00 03950	ANCILLARY	0	0	0	0	0
76.01 03951	PARTIAL HOSPITALIZATION	962,147	95,179	1,057,326	1,233	1,058,559
OUTPATIENT SERVICE COST CENTERS						
91.00 09100	EMERGENCY	4,732,812	3,662,023	8,394,835	-693,781	7,701,054
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE		577,272	577,272	-577,272	0
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	58,025,997	115,355,119	173,381,116	-12,912	173,368,204
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	44,782	4,141	48,923	0	48,923
190.01 19001	MARKETING	0	12,880	12,880	0	12,880
192.00 19200	PHYSICIANS' PRIVATE OFFICES	18,247,028	7,606,270	25,853,298	12,912	25,866,210
194.00 07950	SIRH	0	0	0	0	0
194.01 07951	OTHER NRCC	-65,265	713,811	648,546	0	648,546
200.00	TOTAL (SUM OF LINES 118 through 199)	76,252,542	123,692,221	199,944,763	0	199,944,763

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	-2,643,456	3,935,546	1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	2,799,204	4,575,314	2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	-95,430	7,550,832	4.00
5.01	00540 NONPATIENT TELEPHONES	0	858,583	5.01
5.02	00590 PURCHASING	0	522,293	5.02
5.03	00570 ADMITTING	0	2,797,416	5.03
5.04	00580 CASHIERING/ACCOUNTS RECEIVABLE	0	3,826,634	5.04
5.05	00591 OTHER A&G	-12,378,071	21,611,127	5.05
7.00	00700 OPERATION OF PLANT	-42,337	4,361,342	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	-1	780,147	8.00
9.00	00900 HOUSEKEEPING	0	2,310,397	9.00
10.00	01000 DIETARY	-368,495	806,846	10.00
11.00	01100 CAFETERIA	0	1,432,729	11.00
13.00	01300 NURSING ADMINISTRATION	-165,362	1,616,721	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	-98,015	502,322	14.00
15.00	01500 PHARMACY	0	3,625,004	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	-20,129	1,857,684	16.00
17.00	01700 SOCIAL SERVICE	0	1,654,689	17.00
21.00	02100 I&R SERVICES-SALARY & FRINGES APPRV	0	0	21.00
22.00	02200 I&R SERVICES-OTHER PRGM COSTS APPRV	0	51,640	22.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS	-1,136,554	20,750,901	30.00
31.00	03100 INTENSIVE CARE UNIT	22,867	5,135,718	31.00
32.00	03200 CORONARY CARE UNIT	0	0	32.00
32.01	02060 NEONATAL INTENSIVE CARE UNIT	-477,000	981,276	32.01
40.00	04000 SUBPROVIDER - IPF	9,440	1,411,383	40.00
41.00	04100 SUBPROVIDER - IRF	0	0	41.00
42.00	04200 SUBPROVIDER	0	0	42.00
43.00	04300 NURSERY	2	412,972	43.00
44.00	04400 SKILLED NURSING FACILITY	0	0	44.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	-2,039,214	9,328,158	50.00
51.00	05100 RECOVERY ROOM	0	1,055,845	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	9	1,751,289	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	-227,120	8,496,160	54.00
59.00	05900 CARDIAC CATHETERIZATION	-810	1,899,057	59.00
60.00	06000 LABORATORY	0	4,297,490	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	1,348,808	63.00
64.00	06400 INTRAVENOUS THERAPY	0	787,572	64.00
65.00	06500 RESPIRATORY THERAPY	0	3,309,003	65.00
66.00	06600 PHYSICAL THERAPY	0	776,687	66.00
69.00	06900 ELECTROCARDIOLOGY	0	695,503	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	-3,400	178,210	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	7,491,795	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	6,474,917	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	6,026,282	73.00
74.00	07400 RENAL DIALYSIS	0	458,427	74.00
76.00	03950 ANCILLARY	0	0	76.00
76.01	03951 PARTIAL HOSPITALIZATION	0	1,058,559	76.01
OUTPATIENT SERVICE COST CENTERS				
91.00	09100 EMERGENCY	-198,669	7,502,385	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART			92.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300 INTEREST EXPENSE	0	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	-17,062,541	156,305,663	118.00
NONREIMBURSABLE COST CENTERS				
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	-6,367	42,556	190.00
190.01	19001 MARKETING	0	12,880	190.01
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	25,866,210	192.00
194.00	07950 SIRH	0	0	194.00
194.01	07951 OTHER NRCC	0	648,546	194.01
200.00	TOTAL (SUM OF LINES 118 through 199)	-17,068,908	182,875,855	200.00

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
A - LEASES					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	1,057,338	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
26.00		0.00	0	0	26.00
27.00		0.00	0	0	27.00
28.00		0.00	0	0	28.00
29.00		0.00	0	0	29.00
30.00		0.00	0	0	30.00
	TOTALS		0	1,057,338	
B - CNO RECLASS					
1.00	NURSING ADMINISTRATION	13.00	264,150	18,633	1.00
	TOTALS		264,150	18,633	
C - CAFETERIA					
1.00	CAFETERIA	11.00	562,787	869,942	1.00
	TOTALS		562,787	869,942	
D - MEDICAL SUPPLIES, DRUGS					
1.00	NONPATIENT TELEPHONES	5.01	0	908	1.00
2.00	OPERATION OF PLANT	7.00	0	3,063	2.00
3.00	DIETARY	10.00	0	11,009	3.00
4.00	CENTRAL SERVICES & SUPPLY	14.00	0	2,504	4.00
5.00	ADULTS & PEDIATRICS	30.00	0	6,552	5.00
6.00	SUBPROVIDER - IPF	40.00	0	552	6.00
7.00	INTRAVENOUS THERAPY	64.00	0	371	7.00
8.00	PHYSICAL THERAPY	66.00	0	589	8.00
9.00	ELECTROCARDIOLOGY	69.00	0	224	9.00
10.00	ELECTROENCEPHALOGRAPHY	70.00	0	2,403	10.00
11.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	7,491,795	11.00
12.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	899,930	12.00
13.00	DRUGS CHARGED TO PATIENTS	73.00	0	6,026,282	13.00
14.00	PARTIAL HOSPITALIZATION	76.01	0	220	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
	TOTALS		0	14,446,402	
E - CORP BENEFITS PAID					
1.00	OTHER A&G	5.05	0	97,778	1.00
2.00	NURSING ADMINISTRATION	13.00	0	37,481	2.00
	TOTALS		0	135,259	
F - GENERAL LIABILITY INSURANCE					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	141,500	1.00
	TOTALS		0	141,500	

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
G - REV CODE RECLASS					
1.00	ADULTS & PEDIATRICS	30.00	2,380,232	235,319	1.00
2.00	OPERATING ROOM	50.00	908,756	32,348	2.00
3.00	RECOVERY ROOM	51.00	75,206	47,407	3.00
4.00	CARDIAC CATHETERIZATION	59.00	0	2,631	4.00
5.00	BLOOD STORING, PROCESSING & TRANS.	63.00	426,333	467,683	5.00
6.00	INTRAVENOUS THERAPY	64.00	577,336	140,440	6.00
7.00	RESPIRATORY THERAPY	65.00	361,066	110,012	7.00
8.00	ELECTROENCEPHALOGRAPHY	70.00	33,266	5,254	8.00
9.00		0.00	0	0	9.00
	TOTALS		4,762,195	1,041,094	
H - INTERNS AND RESIDENTS SALARY					
1.00	I&R SERVICES-OTHER PRGM	22.00	51,640	0	1.00
	COSTS APPRV				
	TOTALS		51,640	0	
I - PROPERTY TAX RECLASS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,275,915	1.00
	TOTALS		0	1,275,915	
J - INTEREST EXPENSE					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	577,272	1.00
	TOTALS		0	577,272	
K - COVID					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	2,855	0	1.00
2.00	ADMITTING	5.03	16,966	0	2.00
3.00	LAUNDRY & LINEN SERVICE	8.00	207	0	3.00
4.00	NURSING ADMINISTRATION	13.00	3,891	0	4.00
5.00	PHARMACY	15.00	22,185	0	5.00
6.00	MEDICAL RECORDS & LIBRARY	16.00	593	0	6.00
7.00	ADULTS & PEDIATRICS	30.00	38,403	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	5,395	0	8.00
9.00	NEONATAL INTENSIVE CARE UNIT	32.01	5,675	475	9.00
10.00	SUBPROVIDER - IPF	40.00	10,754	0	10.00
11.00	NURSERY	43.00	829	0	11.00
12.00	OPERATING ROOM	50.00	6,581	845	12.00
13.00	RECOVERY ROOM	51.00	340	0	13.00
14.00	DELIVERY ROOM & LABOR ROOM	52.00	12,922	0	14.00
15.00	RADIOLOGY-DIAGNOSTIC	54.00	8,003	0	15.00
16.00	CARDIAC CATHETERIZATION	59.00	2,994	0	16.00
17.00	LABORATORY	60.00	1,492	0	17.00
18.00	INTRAVENOUS THERAPY	64.00	1,284	0	18.00
19.00	RESPIRATORY THERAPY	65.00	5,970	0	19.00
20.00	PHYSICAL THERAPY	66.00	1,117	0	20.00
21.00	ELECTROCARDIOLOGY	69.00	4,762	0	21.00
22.00	PARTIAL HOSPITALIZATION	76.01	1,013	0	22.00
23.00	EMERGENCY	91.00	7,822	0	23.00
24.00	PHYSICIANS' PRIVATE OFFICES	192.00	12,078	834	24.00
	TOTALS		174,131	2,154	
L - NEGATIVE SALARIES					
1.00	OTHER NRCC	194.01	65,265	0	1.00
	TOTALS		65,265	0	
500.00	Grand Total: Increases		5,880,168	19,565,509	500.00

	Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
A - LEASES						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1,990	10	1.00
2.00	NONPATIENT TELEPHONES	5.01	0	39	0	2.00
3.00	PURCHASING	5.02	0	290,472	0	3.00
4.00	ADMITTING	5.03	0	6,071	0	4.00
5.00	CASHIERING/ACCOUNTS	5.04	0	7,851	0	5.00
	RECEIVABLE					
6.00	OTHER A&G	5.05	0	133,856	0	6.00
7.00	OPERATION OF PLANT	7.00	0	11,461	0	7.00
8.00	LAUNDRY & LINEN SERVICE	8.00	0	71,483	0	8.00
9.00	HOUSEKEEPING	9.00	0	854	0	9.00
10.00	DIETARY	10.00	0	25,202	0	10.00
11.00	CENTRAL SERVICES & SUPPLY	14.00	0	1,585	0	11.00
12.00	PHARMACY	15.00	0	1,119	0	12.00
13.00	MEDICAL RECORDS & LIBRARY	16.00	0	5,229	0	13.00
14.00	SOCIAL SERVICE	17.00	0	1,119	0	14.00
15.00	ADULTS & PEDIATRICS	30.00	0	71,013	0	15.00
16.00	INTENSIVE CARE UNIT	31.00	0	4,951	0	16.00
17.00	NEONATAL INTENSIVE CARE UNIT	32.01	0	49,720	0	17.00
18.00	SUBPROVIDER - IPF	40.00	0	2,074	0	18.00
19.00	NURSERY	43.00	0	24,329	0	19.00
20.00	OPERATING ROOM	50.00	0	6,484	0	20.00
21.00	RECOVERY ROOM	51.00	0	854	0	21.00
22.00	DELIVERY ROOM & LABOR ROOM	52.00	0	4,877	0	22.00
23.00	RADIOLOGY-DIAGNOSTIC	54.00	0	152,599	0	23.00
24.00	CARDIAC CATHETERIZATION	59.00	0	13,747	0	24.00
25.00	LABORATORY	60.00	0	5,804	0	25.00
26.00	INTRAVENOUS THERAPY	64.00	0	854	0	26.00
27.00	RESPIRATORY THERAPY	65.00	0	159,172	0	27.00
28.00	PHYSICAL THERAPY	66.00	0	556	0	28.00
29.00	ELECTROCARDIOLOGY	69.00	0	1,119	0	29.00
30.00	EMERGENCY	91.00	0	854	0	30.00
	TOTALS		0	1,057,338		
B - CNO RECLASS						
1.00	OTHER A&G	5.05	264,150	18,633	0	1.00
	TOTALS		264,150	18,633		
C - CAFETERIA						
1.00	DIETARY	10.00	562,787	869,942	0	1.00
	TOTALS		562,787	869,942		
D - MEDICAL SUPPLIES, DRUGS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	26,768	0	1.00
2.00	PURCHASING	5.02	0	6,990,969	0	2.00
3.00	OTHER A&G	5.05	0	930,212	0	3.00
4.00	OPERATION OF PLANT	7.00	0	210	0	4.00
5.00	HOUSEKEEPING	9.00	0	5,075	0	5.00
6.00	NURSING ADMINISTRATION	13.00	0	11,395	0	6.00
7.00	PHARMACY	15.00	0	4,625,084	0	7.00
8.00	SOCIAL SERVICE	17.00	0	5,502	0	8.00
9.00	ADULTS & PEDIATRICS	30.00	0	2,227	0	9.00
10.00	INTENSIVE CARE UNIT	31.00	0	10,609	0	10.00
11.00	SUBPROVIDER - IPF	40.00	0	1	0	11.00
12.00	NURSERY	43.00	0	2,734	0	12.00
13.00	OPERATING ROOM	50.00	0	330,162	0	13.00
14.00	RECOVERY ROOM	51.00	0	1,227	0	14.00
15.00	DELIVERY ROOM & LABOR ROOM	52.00	0	9,658	0	15.00
16.00	RADIOLOGY-DIAGNOSTIC	54.00	0	298,479	0	16.00
17.00	CARDIAC CATHETERIZATION	59.00	0	23,221	0	17.00
18.00	LABORATORY	60.00	0	817,485	0	18.00
19.00	INTRAVENOUS THERAPY	64.00	0	171,110	0	19.00
20.00	RESPIRATORY THERAPY	65.00	0	163,517	0	20.00
21.00	ELECTROCARDIOLOGY	69.00	0	14,169	0	21.00
22.00	EMERGENCY	91.00	0	6,588	0	22.00
	TOTALS		0	14,446,402		
E - CORP BENEFITS PAID						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	135,259	0	1.00
2.00		0.00	0	0	0	2.00
	TOTALS		0	135,259		
F - GENERAL LIABILITY INSURANCE						
1.00	OTHER A&G	5.05	0	141,500	12	1.00
	TOTALS		0	141,500		
G - REV CODE RECLASS						
1.00	INTENSIVE CARE UNIT	31.00	2,454,994	241,079	0	1.00
2.00	NEONATAL INTENSIVE CARE UNIT	32.01	266,684	61,452	0	2.00
3.00	NURSERY	43.00	108,752	24,907	0	3.00

12/22/2022 2:33 pm C:\Users\NRA6265\OneDrive - LifePoint Health\Reimbursement\Clark Memorial IN\Cost Reports\7.31.2022\0.0 HFS\A1

Decreases							
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
4.00	DELIVERY ROOM & LABOR ROOM		52.00	269,715	61,394	0	4.00
5.00	RADIOLOGY-DIAGNOSTIC		54.00	554,606	61,119	0	5.00
6.00	CARDIAC CATHETERIZATION		59.00	133,581	0	0	6.00
7.00	LABORATORY		60.00	349,202	448,027	0	7.00
8.00	ELECTROCARDIOLOGY		69.00	66,352	7,264	0	8.00
9.00	EMERGENCY		91.00	558,309	135,852	0	9.00
	TOTALS			4,762,195	1,041,094		
H - INTERNS AND RESIDENTS SALARY							
1.00	MEDICAL RECORDS & LIBRARY		16.00	51,640	0	0	1.00
	TOTALS			51,640	0		
I - PROPERTY TAX RECLASS							
1.00	OTHER A&G		5.05	0	1,275,915	13	1.00
	TOTALS			0	1,275,915		
J - INTEREST EXPENSE							
1.00	INTEREST EXPENSE		113.00	0	577,272	11	1.00
	TOTALS			0	577,272		
K - COVID							
1.00	OTHER A&G		5.05	174,131	2,154	0	1.00
2.00			0.00	0	0	0	2.00
3.00			0.00	0	0	0	3.00
4.00			0.00	0	0	0	4.00
5.00			0.00	0	0	0	5.00
6.00			0.00	0	0	0	6.00
7.00			0.00	0	0	0	7.00
8.00			0.00	0	0	0	8.00
9.00			0.00	0	0	0	9.00
10.00			0.00	0	0	0	10.00
11.00			0.00	0	0	0	11.00
12.00			0.00	0	0	0	12.00
13.00			0.00	0	0	0	13.00
14.00			0.00	0	0	0	14.00
15.00			0.00	0	0	0	15.00
16.00			0.00	0	0	0	16.00
17.00			0.00	0	0	0	17.00
18.00			0.00	0	0	0	18.00
19.00			0.00	0	0	0	19.00
20.00			0.00	0	0	0	20.00
21.00			0.00	0	0	0	21.00
22.00			0.00	0	0	0	22.00
23.00			0.00	0	0	0	23.00
24.00			0.00	0	0	0	24.00
	TOTALS			174,131	2,154		
L - NEGATIVE SALARIES							
1.00	OTHER NRCC		194.01	0	65,265	0	1.00
	TOTALS			0	65,265		
500.00	Grand Total: Decreases			5,814,903	19,630,774		500.00

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
			1.00	2.00	3.00	4.00	5.00
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	5,945,943	0	0	0	0	1.00
2.00	Land Improvements	1,714,775	0	0	0	0	2.00
3.00	Buildings and Fixtures	90,049,676	0	0	0	0	3.00
4.00	Building Improvements	656,183	0	0	0	0	4.00
5.00	Fixed Equipment	96,895,397	919,268	0	919,268	0	5.00
6.00	Movable Equipment	60,408,942	2,472,668	0	2,472,668	365,975	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	255,670,916	3,391,936	0	3,391,936	365,975	8.00
9.00	Reconciling Items	196,604,834	0	0	0	254,351	9.00
10.00	Total (line 8 minus line 9)	59,066,082	3,391,936	0	3,391,936	111,624	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	5,945,943	0	0	0	0	1.00
2.00	Land Improvements	1,714,775	0	0	0	0	2.00
3.00	Buildings and Fixtures	90,049,676	0	0	0	0	3.00
4.00	Building Improvements	656,183	0	0	0	0	4.00
5.00	Fixed Equipment	97,814,665	0	0	0	0	5.00
6.00	Movable Equipment	62,515,635	0	0	0	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	258,696,877	0	0	0	0	8.00
9.00	Reconciling Items	196,350,483	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	62,346,394	0	0	0	0	10.00

Cost Center Description		SUMMARY OF CAPITAL				
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)
		9.00	10.00	11.00	12.00	13.00
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	5,303,087	0	0	0	0 1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0 2.00
3.00	Total (sum of lines 1-2)	5,303,087	0	0	0	0 3.00
Cost Center Description		SUMMARY OF CAPITAL				
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)			
		14.00	15.00			
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	5,303,087			1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0			2.00
3.00	Total (sum of lines 1-2)	0	5,303,087			3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0009

Period:
From 08/01/2021
To 07/31/2022Worksheet A-7
Part III
Date/Time Prepared:
12/22/2022 2:33 pm

Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL	
	Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance
	1.00	2.00	3.00	4.00	5.00
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS					
1.00 CAP REL COSTS-BLDG & FIXT	47,280,018	0	47,280,018	0.758344	0
2.00 CAP REL COSTS-MVBLE EQUIP	15,066,376	0	15,066,376	0.241656	0
3.00 Total (sum of lines 1-2)	62,346,394	0	62,346,394	1.000000	0
ALLOCATION OF OTHER CAPITAL					
Cost Center Description	Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease
	6.00	7.00	8.00	9.00	10.00
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS					
1.00 CAP REL COSTS-BLDG & FIXT	0	0	0	2,659,631	0
2.00 CAP REL COSTS-MVBLE EQUIP	0	0	0	3,376,476	1,057,338
3.00 Total (sum of lines 1-2)	0	0	0	6,036,107	1,057,338
SUMMARY OF CAPITAL					
Cost Center Description	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)
	11.00	12.00	13.00	14.00	15.00
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS					
1.00 CAP REL COSTS-BLDG & FIXT	0	0	1,275,915	0	3,935,546
2.00 CAP REL COSTS-MVBLE EQUIP	0	141,500	0	0	4,575,314
3.00 Total (sum of lines 1-2)	0	141,500	1,275,915	0	8,510,860

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)			0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)			0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)			0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)	B		0	OTHER A&G	5.05	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		0	CAP REL COSTS-MVBLE EQUIP	2.00	9	7.00
8.00	Television and radio service (chapter 21)			0		0.00	9	8.00
9.00	Parking lot (chapter 21)			0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-3,959,048			0.00	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	29,438				0	12.00
13.00	Laundry and linen service			0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-356,855	DIETARY		10.00	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	-841	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	-11,640	DIETARY		10.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)	B		0	OTHER A&G	5.05	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	-2,643,456	CAP REL COSTS-BLDG & FIXT		1.00	9	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	A	3,376,476	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	*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)	A	-104,424	ADULTS & PEDIATRICS		30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest			0		0.00	0	32.00

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From which the Amount is to be Adjusted		
				Cost Center	Line #	Wkst. A-7 Ref.
				1.00	2.00	3.00
33.00	GIFT SHOP	B	-6,367	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00	0 33.00
36.00	OTHER MISCELLANEOUS INCOME	B	-56,901	OTHER A&G	5.05	0 36.00
37.00	INTEREST INCOME	B	-6,727	OTHER A&G	5.05	0 37.00
37.01	PATIENT TV ELECTRICITY	A	-7,496	OPERATION OF PLANT	7.00	0 37.01
38.00	PATIENT TV - CABLE	A	-35,979	OPERATION OF PLANT	7.00	0 38.00
39.00	TELEPHONE SERVICES	A	-27,667	OTHER A&G	5.05	0 39.00
40.00	PATIENT PHONE MAINTENANCE	A	1,156	OPERATION OF PLANT	7.00	0 40.00
42.00	PATIENT TELEPHONE SALARIES	A	-31,681	OTHER A&G	5.05	0 42.00
43.00	PATIENT TELEPHONE - BENEFITS	A	-5,671	EMPLOYEE BENEFITS DEPARTMENT	4.00	0 43.00
44.00	OTHER A&G ADVERTISING	A	-888,657	OTHER A&G	5.05	0 44.00
46.00	LOST CHARGES	A	9	DELIVERY ROOM & LABOR ROOM	52.00	0 46.00
48.00	OPERATING ROOM ADVERTISING	A	-25	OPERATING ROOM	50.00	0 48.00
49.00	LOBBYING	A	-14,216	OTHER A&G	5.05	0 49.00
49.01	LOST CHARGES	A	-1	LAUNDRY & LINEN SERVICE	8.00	0 49.01
49.02	LOST CHARGES	A	2	NURSERY	43.00	0 49.02
49.03	LOST CHARGES	A	-7	MEDICAL RECORDS & LIBRARY	16.00	0 49.03
49.04	LOST CHARGES	A	-3,329	ADULTS & PEDIATRICS	30.00	0 49.04
49.05	LOST CHARGES	A	167	INTENSIVE CARE UNIT	31.00	0 49.05
49.06	LOST CHARGES	A	-2,142	OPERATING ROOM	50.00	0 49.06
49.07	LOST CHARGES	A	-810	CARDIAC CATHETERIZATION	59.00	0 49.07
49.08	LOST CHARGES	A	21	EMERGENCY	91.00	0 49.08
49.09	NON PATIENT GIFTS	A	-13,886	OTHER A&G	5.05	0 49.09
49.10	PARTIES/BANQUETS	A	-11,550	OTHER A&G	5.05	0 49.10
49.11	ALCOHOLIC BEVERAGES	A	-709	OTHER A&G	5.05	0 49.11
49.12	DONATIONS	A	-144,763	OTHER A&G	5.05	0 49.12
49.13	PROVIDER TAX	A	-11,110,252	OTHER A&G	5.05	0 49.13
49.14	NON-EMERGENT AMBULANCE	A	-165,362	NURSING ADMINISTRATION	13.00	0 49.14
49.15	PHYSICIAN RECRUITING	A	-381,705	OTHER A&G	5.05	0 49.15
49.16	LOST CHARGES	A	66	RADIOLOGY-DIAGNOSTIC	54.00	0 49.16
49.17	PARTIES/BANQUETS	A	-18	OPERATION OF PLANT	7.00	0 49.17
49.18	PENALTIES	A	-182	OTHER A&G	5.05	0 49.18
49.19	LEGAL SETTLEMENT	A	-483,659	OTHER A&G	5.05	0 49.19
49.20	PATIENT TAXI	A	-217	ADULTS & PEDIATRICS	30.00	0 49.20
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-17,068,908			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: 15-0009

Period:
From 08/01/2021
To 07/31/2022Worksheet A-8-1
Date/Time Prepared:
12/22/2022 2:33 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
					1.00	2.00
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:						
1.00	2.00	CAP REL COSTS-MVBLE EQUIP	HOME OFFICE INTEREST	0	577,272	1.00
2.00	5.05	OTHER A&G	HOME OFFICE MANAGEMENT	6,628,784	5,364,172	2.00
3.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	C SUITE PAYROLL TAXES	-89,759	0	3.00
4.00	14.00	CENTRAL SERVICES & SUPPLY	HPG PURCHASING	102,049	200,064	4.00
4.01	5.05	OTHER A&G	MALPRACTICE	141,346	611,474	4.01
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			6,782,420	6,752,982	5.00

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

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

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

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

6.00	B		0.00	LIFEPOINT HEALT	100.00	6.00
7.00	B		0.00	HEALTHTRUST HPG	4.58	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: 15-0009	Period: From 08/01/2021 To 07/31/2022	Worksheet A-8-1
		Date/Time Prepared: 12/22/2022 2:33 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	-577,272	11	1.00
2.00	1,264,612	0	2.00
3.00	-89,759	0	3.00
4.00	-98,015	0	4.00
4.01	-470,128	0	4.01
5.00	29,438		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 requested information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

6.00	HOSPITAL MGMT	6.00
7.00	PURCHASING	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.

	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	31.00	AGGREGATE-INTENSIVE CARE UNIT	-87,500	-87,500	0	0	0	1.00
2.00	31.00	AGGREGATE-INTENSIVE CARE UNIT	64,800	64,800	0	0	0	2.00
3.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	206,543	206,543	0	0	0	3.00
4.00	40.00	AGGREGATE-SUBPROVIDER - IPF	-5,000	-5,000	0	0	0	4.00
5.00	40.00	AGGREGATE-SUBPROVIDER - IPF	-9,440	-9,440	0	0	0	5.00
6.00	40.00	AGGREGATE-SUBPROVIDER - IPF	5,000	5,000	0	0	0	6.00
7.00	32.01	AGGREGATE-NEONATAL INTENSIVE CARE UN	475,000	475,000	0	0	0	7.00
8.00	32.01	AGGREGATE-NEONATAL INTENSIVE CARE UN	2,000	2,000	0	0	0	8.00
9.00	50.00	AGGREGATE-OPERATING ROOM	132,880	132,880	0	0	0	9.00
10.00	50.00	AGGREGATE-OPERATING ROOM	1,904,167	1,904,167	0	0	0	10.00
11.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	31,250	31,250	0	0	0	11.00
12.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	191,769	191,769	0	0	0	12.00
13.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	4,167	4,167	0	0	0	13.00
14.00	70.00	AGGREGATE-ELECTROENCEPHALOGRAPHY	3,400	3,400	0	0	0	14.00
15.00	91.00	AGGREGATE-EMERGENCY	198,690	198,690	0	0	0	15.00
16.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	646,600	646,600	0	0	0	16.00
17.00	16.00	AGGREGATE-MEDICAL RECORDS & LIBRARY	19,281	19,281	0	0	0	17.00
18.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	357,555	0	357,555	211,500	1,791	18.00
200.00			4,141,162	3,783,607	357,555		1,791	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	31.00	AGGREGATE-INTENSIVE CARE UNIT	0	0	0	0	0	1.00
2.00	31.00	AGGREGATE-INTENSIVE CARE UNIT	0	0	0	0	0	2.00
3.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	0	0	0	0	0	3.00
4.00	40.00	AGGREGATE-SUBPROVIDER - IPF	0	0	0	0	0	4.00
5.00	40.00	AGGREGATE-SUBPROVIDER - IPF	0	0	0	0	0	5.00
6.00	40.00	AGGREGATE-SUBPROVIDER - IPF	0	0	0	0	0	6.00
7.00	32.01	AGGREGATE-NEONATAL INTENSIVE CARE UN	0	0	0	0	0	7.00
8.00	32.01	AGGREGATE-NEONATAL INTENSIVE CARE UN	0	0	0	0	0	8.00
9.00	50.00	AGGREGATE-OPERATING ROOM	0	0	0	0	0	9.00
10.00	50.00	AGGREGATE-OPERATING ROOM	0	0	0	0	0	10.00
11.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	11.00
12.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	12.00
13.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	13.00
14.00	70.00	AGGREGATE-ELECTROENCEPHALOGRAPHY	0	0	0	0	0	14.00
15.00	91.00	AGGREGATE-EMERGENCY	0	0	0	0	0	15.00
16.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	0	0	0	0	0	16.00
17.00	16.00	AGGREGATE-MEDICAL RECORDS & LIBRARY	0	0	0	0	0	17.00
18.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	182,114	9,106	0	0	0	18.00
200.00			182,114	9,106	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	31.00	AGGREGATE-INTENSIVE CARE UNIT	0	0	0	-87,500		1.00

	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
2.00	31.00	AGGREGATE-INTENSIVE CARE UNIT		0	0	0	64,800		2.00
3.00	30.00	AGGREGATE-ADULTS & PEDIATRICS		0	0	0	206,543		3.00
4.00	40.00	AGGREGATE-SUBPROVIDER - IPF		0	0	0	-5,000		4.00
5.00	40.00	AGGREGATE-SUBPROVIDER - IPF		0	0	0	-9,440		5.00
6.00	40.00	AGGREGATE-SUBPROVIDER - IPF		0	0	0	5,000		6.00
7.00	32.01	AGGREGATE-NEONATAL INTENSIVE CARE UN		0	0	0	475,000		7.00
8.00	32.01	AGGREGATE-NEONATAL INTENSIVE CARE UN		0	0	0	2,000		8.00
9.00	50.00	AGGREGATE-OPERATING ROOM		0	0	0	132,880		9.00
10.00	50.00	AGGREGATE-OPERATING ROOM		0	0	0	1,904,167		10.00
11.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOST IC		0	0	0	31,250		11.00
12.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOST IC		0	0	0	191,769		12.00
13.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOST IC		0	0	0	4,167		13.00
14.00	70.00	AGGREGATE-ELECTROENCEPHALOGR APHY		0	0	0	3,400		14.00
15.00	91.00	AGGREGATE-EMERGENCY		0	0	0	198,690		15.00
16.00	30.00	AGGREGATE-ADULTS & PEDIATRICS		0	0	0	646,600		16.00
17.00	16.00	AGGREGATE-MEDICAL RECORDS & LIBRARY		0	0	0	19,281		17.00
18.00	30.00	AGGREGATE-ADULTS & PEDIATRICS		0	182,114	175,441	175,441		18.00
200.00				0	182,114	175,441	3,959,048		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0009

Period:
From 08/01/2021
To 07/31/2022Worksheet B
Part I
Date/Time Prepared:
12/22/2022 2:33 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	NONPATIENT TELEPHONES	
		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	3,935,546	3,935,546			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	4,575,314		4,575,314		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	7,550,832	0	0	7,550,832	4.00
5.01 00540	NONPATIENT TELEPHONES	858,583	0	0	25,695	884,278
5.02 00590	PURCHASING	522,293	19,909	23,146	54,970	13,081
5.03 00570	ADMITTING	2,797,416	146,901	170,781	212,955	12,209
5.04 00580	CASHIERING/ACCOUNTS RECEIVABLE	3,826,634	217,238	252,553	0	40,115
5.05 00591	OTHER A&G	21,611,127	353,056	410,449	507,021	256,390
7.00 00700	OPERATION OF PLANT	4,361,342	587,846	683,407	89,130	24,418
8.00 00800	LAUNDRY & LINEN SERVICE	780,147	0	0	8,766	1,744
9.00 00900	HOUSEKEEPING	2,310,397	0	0	166	0
10.00 01000	DIETARY	806,846	184,714	214,742	46,705	14,825
11.00 01100	CAFETERIA	1,432,729	0	0	56,253	0
13.00 01300	NURSING ADMINISTRATION	1,616,721	31,597	36,733	111,993	4,360
14.00 01400	CENTRAL SERVICES & SUPPLY	502,322	61,179	71,124	27,578	6,977
15.00 01500	PHARMACY	3,625,004	37,723	43,855	252,846	12,209
16.00 01600	MEDICAL RECORDS & LIBRARY	1,857,684	0	0	59,314	40,115
17.00 01700	SOCIAL SERVICE	1,654,689	0	0	120,146	14,825
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRV	51,640	0	0	5,162	0
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	20,750,901	767,453	892,210	1,275,422	71,510
31.00 03100	INTENSIVE CARE UNIT	5,135,718	74,267	86,340	52,406	23,546
32.00 03200	CORONARY CARE UNIT	0	0	0	0	0
32.01 02060	NEONATAL INTENSIVE CARE UNIT	981,276	0	0	76,174	8,721
40.00 04000	SUBPROVIDER - IPF	1,411,383	164,674	191,444	115,605	0
41.00 04100	SUBPROVIDER - IRF	0	0	0	0	0
42.00 04200	SUBPROVIDER	0	0	0	0	0
43.00 04300	NURSERY	412,972	0	0	29,623	0
44.00 04400	SKILLED NURSING FACILITY	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	9,328,158	394,970	459,177	458,980	0
51.00 05100	RECOVERY ROOM	1,055,845	0	0	92,020	0
52.00 05200	DELIVERY ROOM & LABOR ROOM	1,751,289	153,883	178,899	154,198	61,045
54.00 05400	RADIOLOGY-DIAGNOSTIC	8,496,160	280,492	326,089	484,229	0
59.00 05900	CARDIAC CATHETERIZATION	1,899,057	64,483	74,966	166,351	12,209
60.00 06000	LABORATORY	4,297,490	115,344	134,095	203,618	12,209
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	1,348,808	0	0	42,614	43,603
64.00 06400	INTRAVENOUS THERAPY	787,572	0	0	63,496	18,313
65.00 06500	RESPIRATORY THERAPY	3,309,003	0	0	263,796	31,394
66.00 06600	PHYSICAL THERAPY	776,687	0	0	71,863	0
69.00 06900	ELECTROCARDIOLOGY	695,503	38,206	44,417	62,941	2,616
70.00 07000	ELECTROENCEPHALOGRAPHY	178,210	6,207	7,215	14,918	0
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	7,491,795	0	0	0	6,104
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	6,474,917	0	0	0	10,465
73.00 07300	DRUGS CHARGED TO PATIENTS	6,026,282	0	0	0	4,360
74.00 07400	RENAL DIALYSIS	458,427	0	0	0	0
76.00 03950	ANCILLARY	0	0	0	0	76.00
76.01 03951	PARTIAL HOSPITALIZATION	1,058,559	0	0	96,273	0
OUTPATIENT SERVICE COST CENTERS						
91.00 09100	EMERGENCY	7,502,385	204,331	237,548	418,044	44,476
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART					91.00 92.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	156,305,663	3,904,473	4,539,190	5,721,271	791,839
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	42,556	8,222	9,558	4,476	0
190.01 19001	MARKETING	12,880	0	0	0	0
192.00 19200	PHYSICIANS' PRIVATE OFFICES	25,866,210	0	0	1,825,085	0
194.00 07950	SIRH	0	0	0	0	92,439
194.01 07951	OTHER NRCC	648,546	22,851	26,566	0	0
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers		0	0	0	0
202.00	TOTAL (sum lines 118 through 201)	182,875,855	3,935,546	4,575,314	7,550,832	884,278
						202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0009

Period:
From 08/01/2021
To 07/31/2022Worksheet B
Part I
Date/Time Prepared:
12/22/2022 2:33 pm

Cost Center Description	PURCHASING	ADMITTING	CASHIERING/ACCOUNTS RECEIVABLE	Subtotal	OTHER A&G	
	5.02	5.03	5.04	5A.04	5.05	
GENERAL SERVICE COST CENTERS						
1.00 00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00 00200 CAP REL COSTS-MVBL EQUIP						2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01 00540 NONPATIENT TELEPHONES						5.01
5.02 00590 PURCHASING	633,399					5.02
5.03 00570 ADMITTING	6,814	3,347,076				5.03
5.04 00580 CASHIERING/ACCOUNTS RECEIVABLE	620	0	4,337,160			5.04
5.05 00591 OTHER A&G	65,433	0	0	23,203,476	23,203,476	5.05
7.00 00700 OPERATION OF PLANT	47,877	0	0	5,794,020	841,981	7.00
8.00 00800 LAUNDRY & LINEN SERVICE	1,401	0	0	792,058	115,101	8.00
9.00 00900 HOUSEKEEPING	20,971	0	0	2,331,534	338,816	9.00
10.00 01000 DIETARY	32,499	0	0	1,300,331	188,963	10.00
11.00 01100 CAFETERIA	0	0	0	1,488,982	216,377	11.00
13.00 01300 NURSING ADMINISTRATION	16,575	0	0	1,817,979	264,187	13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	17,641	0	0	686,821	99,808	14.00
15.00 01500 PHARMACY	10,118	0	0	3,981,755	578,625	15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	1,074	0	0	1,958,187	284,562	16.00
17.00 01700 SOCIAL SERVICE	791	0	0	1,790,451	260,187	17.00
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	56,802	8,254	22.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS	52,164	331,567	429,626	24,570,853	3,570,612	30.00
31.00 03100 INTENSIVE CARE UNIT	30,823	56,613	73,356	5,533,069	804,060	31.00
32.00 03200 CORONARY CARE UNIT	0	0	0	0	0	32.00
32.01 02060 NEONATAL INTENSIVE CARE UNIT	0	10,854	14,065	1,091,090	158,556	32.01
40.00 04000 SUBPROVIDER - IPF	2,424	13,650	17,687	1,916,867	278,557	40.00
41.00 04100 SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00 04200 SUBPROVIDER	0	0	0	0	0	42.00
43.00 04300 NURSERY	5,346	11,633	15,073	474,647	68,975	43.00
44.00 04400 SKILLED NURSING FACILITY	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	40,554	428,862	555,695	11,666,396	1,695,349	50.00
51.00 05100 RECOVERY ROOM	2,391	36,183	46,885	1,233,324	179,225	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	8,263	14,891	19,295	2,341,763	340,303	52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	29,383	516,793	669,835	10,802,981	1,569,878	54.00
59.00 05900 CARDIAC CATHETERIZATION	3,107	90,108	116,757	2,427,038	352,695	59.00
60.00 06000 LABORATORY	145,765	368,885	477,981	5,755,387	836,367	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	128,391	166,362	1,729,778	251,370	63.00
64.00 06400 INTRAVENOUS THERAPY	378	21,100	27,340	918,199	133,432	64.00
65.00 06500 RESPIRATORY THERAPY	10,943	216,937	281,095	4,113,168	597,721	65.00
66.00 06600 PHYSICAL THERAPY	103	17,694	22,927	889,274	129,228	66.00
69.00 06900 ELECTROCARDIOLOGY	2,307	76,580	99,228	1,021,798	148,487	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	1,103	20,958	27,156	255,767	37,168	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	263,195	341,033	8,102,127	1,177,393	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	90,485	117,246	6,693,113	972,636	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	319,339	413,782	6,763,763	982,903	73.00
74.00 07400 RENAL DIALYSIS	0	1,828	2,368	462,623	67,228	74.00
76.00 03950 ANCILLARY	0	0	0	0	0	76.00
76.01 03951 PARTIAL HOSPITALIZATION	1,477	14,914	19,325	1,190,548	173,009	76.01
OUTPATIENT SERVICE COST CENTERS						
91.00 09100 EMERGENCY	34,446	295,616	383,043	9,119,889	1,325,293	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300 INTEREST EXPENSE						113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	592,791	3,347,076	4,337,160	154,275,858	19,047,306	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	64,812	9,418	190.00
190.01 19001 MARKETING	0	0	0	12,880	1,872	190.01
192.00 19200 PHYSICIANS' PRIVATE OFFICES	40,477	0	0	27,731,772	4,030,001	192.00
194.00 07950 SIRH	0	0	0	92,439	13,433	194.00
194.01 07951 OTHER NRCC	131	0	0	698,094	101,446	194.01
200.00 Cross Foot Adjustments				0	200.00	
201.00 Negative Cost Centers	0	0	0	0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	633,399	3,347,076	4,337,160	182,875,855	23,203,476	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0009

Period:
From 08/01/2021
To 07/31/2022Worksheet B
Part I
Date/Time Prepared:
12/22/2022 2:33 pm

Cost Center Description		OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
		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-MVBL EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540 NONPATIENT TELEPHONES						5.01
5.02	00590 PURCHASING						5.02
5.03	00570 ADMITTING						5.03
5.04	00580 CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05	00591 OTHER A&G						5.05
7.00	00700 OPERATION OF PLANT	6,636,001					7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	907,159				8.00
9.00	00900 HOUSEKEEPING	0	0	2,670,350			9.00
10.00	01000 DIETARY	469,535	0	9,270	1,968,099		10.00
11.00	01100 CAFETERIA	0	0	0	0	1,705,359	11.00
13.00	01300 NURSING ADMINISTRATION	80,317	0	2,648	0	28,423	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	155,513	0	33,106	0	0	14.00
15.00	01500 PHARMACY	95,889	0	9,270	0	85,268	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	0	5,297	0	36,949	16.00
17.00	01700 SOCIAL SERVICE	0	0	0	0	45,476	17.00
21.00	02100 I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200 I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	1,950,822	394,019	1,299,090	1,305,875	520,135	30.00
31.00	03100 INTENSIVE CARE UNIT	188,782	137,448	359,534	243,044	51,161	31.00
32.00	03200 CORONARY CARE UNIT	0	0	0	0	0	32.00
32.01	02060 NEONATAL INTENSIVE CARE UNIT	0	0	0	0	22,738	32.01
40.00	04000 SUBPROVIDER - IPF	418,593	27,490	168,842	294,609	39,792	40.00
41.00	04100 SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200 SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300 NURSERY	0	9,163	662	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	1,003,994	210,754	114,548	0	167,694	50.00
51.00	05100 RECOVERY ROOM	0	0	0	0	28,423	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	391,164	27,490	168,842	29,933	48,319	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	712,997	27,490	131,763	0	153,482	54.00
59.00	05900 CARDIAC CATHETERIZATION	163,913	18,326	33,106	0	36,949	59.00
60.00	06000 LABORATORY	293,200	0	59,591	0	90,952	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0	0	19,896	64.00
65.00	06500 RESPIRATORY THERAPY	0	0	662	0	88,110	65.00
66.00	06600 PHYSICAL THERAPY	0	0	1,324	0	22,738	66.00
69.00	06900 ELECTROCARDIOLOGY	97,119	0	3,311	0	22,738	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	15,777	0	1,324	0	5,685	70.00
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
74.00	07400 RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950 ANCILLARY	0	0	0	0	0	76.00
76.01	03951 PARTIAL HOSPITALIZATION	0	0	1,986	0	36,949	76.01
OUTPATIENT SERVICE COST CENTERS							
91.00	09100 EMERGENCY	519,400	54,979	264,850	94,638	153,482	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)					92.00	
SPECIAL PURPOSE COST CENTERS							
113.00	11300 INTEREST EXPENSE						113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	6,557,015	907,159	2,669,026	1,968,099	1,705,359	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	20,899	0	1,324	0	0	190.00
190.01	19001 MARKETING	0	0	0	0	0	190.01
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950 SIRH	0	0	0	0	0	194.00
194.01	07951 OTHER NRCC	58,087	0	0	0	0	194.01
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	6,636,001	907,159	2,670,350	1,968,099	1,705,359	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0009

Period:
From 08/01/2021
To 07/31/2022Worksheet B
Part I
Date/Time Prepared:
12/22/2022 2:33 pm

Cost Center Description		NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal					
						13.00	14.00	15.00	16.00	16A	
GENERAL SERVICE COST CENTERS											
1.00	00100	CAP REL COSTS-BLDG & FIXT									1.00
2.00	00200	CAP REL COSTS-MVBL EQUIP									2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT									4.00
5.01	00540	NONPATIENT TELEPHONES									5.01
5.02	00590	PURCHASING									5.02
5.03	00570	ADMITTING									5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE									5.04
5.05	00591	OTHER A&G									5.05
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	2,193,554								13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	975,248							14.00
15.00	01500	PHARMACY	157,810	0	4,908,617						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	2,284,995					16.00
17.00	01700	SOCIAL SERVICE	0	0	5,547	0	2,101,661				17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0				21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	65,056				22.00
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS	962,640	0	2,229	1,810,745	36,387,020				30.00
31.00	03100	INTENSIVE CARE UNIT	94,686	899	1,571	128,934	7,543,188				31.00
32.00	03200	CORONARY CARE UNIT	0	0	0	0	0				32.00
32.01	02060	NEONATAL INTENSIVE CARE UNIT	42,083	0	0	19,101	1,333,568				32.01
40.00	04000	SUBPROVIDER - IPF	73,644	0	1	166,241	3,384,636				40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0				41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0				42.00
43.00	04300	NURSERY	21,041	269	27	150,423	725,207				43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0				44.00
ANCILLARY SERVICE COST CENTERS											
50.00	05000	OPERATING ROOM	310,359	11,523	215,917	0	15,396,534				50.00
51.00	05100	RECOVERY ROOM	52,603	122	2	1,642	1,495,341				51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	89,425	931	283	7,909	3,446,362				52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	29,571	780	0	13,428,942				54.00
59.00	05900	CARDIAC CATHETERIZATION	68,384	2,239	690	0	3,103,340				59.00
60.00	06000	LABORATORY	0	79,448	17,796	0	7,132,741				60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	1,981,148				63.00
64.00	06400	INTRAVENOUS THERAPY	36,822	0	172,522	0	1,280,871				64.00
65.00	06500	RESPIRATORY THERAPY	0	16,178	649	0	4,816,488				65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	1,042,564				66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	14,286	0	1,307,739				69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	315,721				70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	744,157	0	0	10,023,677				71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	89,390	0	0	7,755,139				72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	4,474,960	0	12,221,626				73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	529,851				74.00
76.00	03950	ANCILLARY	0	0	0	0	0				76.00
76.01	03951	PARTIAL HOSPITALIZATION	0	0	0	0	1,402,492				76.01
OUTPATIENT SERVICE COST CENTERS											
91.00	09100	EMERGENCY	284,057	521	1,357	0	11,818,466				91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0				0				92.00
SPECIAL PURPOSE COST CENTERS											
113.00	11300	INTEREST EXPENSE									113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,193,554	975,248	4,908,617	2,284,995	150,039,378				118.00
NONREIMBURSABLE COST CENTERS											
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	96,453				190.00
190.01	19001	MARKETING	0	0	0	0	14,752				190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	31,761,773				192.00
194.00	07950	SIRH	0	0	0	0	105,872				194.00
194.01	07951	OTHER NRCC	0	0	0	0	857,627				194.01
200.00		Cross Foot Adjustments	0				0				200.00
201.00		Negative Cost Centers	0	0	0	0	0				201.00
202.00		TOTAL (sum lines 118 through 201)	2,193,554	975,248	4,908,617	2,284,995	182,875,855				202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0009

Period:

From 08/01/2021

To 07/31/2022

Worksheet B

Part I

Date/Time Prepared:

12/22/2022 2:33 pm

Cost Center Description	SOCIAL SERVICE	INTERNS & RESIDENTS		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		SERVICES-SALAR Y & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV			
		17.00	21.00	22.00	24.00	25.00
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 00540	NONPATIENT TELEPHONES					5.01
5.02 00590	PURCHASING					5.02
5.03 00570	ADMITTING					5.03
5.04 00580	CASHIERING/ACCOUNTS RECEIVABLE					5.04
5.05 00591	OTHER A&G					5.05
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	2,101,661	0			17.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0			21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRV	756	65,812			22.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	423,018	0	65,812	36,875,850	-65,812
31.00 03100	INTENSIVE CARE UNIT	87,697	0	0	7,630,885	0
32.00 03200	CORONARY CARE UNIT	0	0	0	0	0
32.01 02060	NEONATAL INTENSIVE CARE UNIT	15,504	0	0	1,349,072	0
40.00 04000	SUBPROVIDER - IPF	39,350	0	0	3,423,986	0
41.00 04100	SUBPROVIDER - IRF	0	0	0	0	0
42.00 04200	SUBPROVIDER	0	0	0	0	0
43.00 04300	NURSERY	8,431	0	0	733,638	0
44.00 04400	SKILLED NURSING FACILITY	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	179,000	0	0	15,575,534	0
51.00 05100	RECOVERY ROOM	17,385	0	0	1,512,726	0
52.00 05200	DELIVERY ROOM & LABOR ROOM	40,067	0	0	3,486,429	0
54.00 05400	RADIOLOGY-DIAGNOSTIC	156,125	0	0	13,585,067	0
59.00 05900	CARDIAC CATHETERIZATION	36,079	0	0	3,139,419	0
60.00 06000	LABORATORY	82,925	0	0	7,215,666	0
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	23,033	0	0	2,004,181	0
64.00 06400	INTRAVENOUS THERAPY	14,891	0	0	1,295,762	0
65.00 06500	RESPIRATORY THERAPY	55,996	0	0	4,872,484	0
66.00 06600	PHYSICAL THERAPY	12,121	0	0	1,054,685	0
69.00 06900	ELECTROCARDIOLOGY	15,204	0	0	1,322,943	0
70.00 07000	ELECTROENCEPHALOGRAPHY	3,671	0	0	319,392	0
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	116,535	0	0	10,140,212	0
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	90,161	0	0	7,845,300	0
73.00 07300	DRUGS CHARGED TO PATIENTS	142,089	0	0	12,363,715	0
74.00 07400	RENAL DIALYSIS	6,160	0	0	536,011	0
76.00 03950	ANCILLARY	0	0	0	0	0
76.01 03951	PARTIAL HOSPITALIZATION	16,305	0	0	1,418,797	0
OUTPATIENT SERVICE COST CENTERS						
91.00 09100	EMERGENCY	137,401	0	0	11,955,867	0
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
118.00	Subtotals (sum of lines 1 through 117)	1,719,904	0	65,812	149,657,621	-65,812
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,121	0	0	97,574	0
190.01 19001	MARKETING	172	0	0	14,924	0
192.00 19200	PHYSICIANS' PRIVATE OFFICES	369,262	0	0	32,131,035	0
194.00 07950	SIRH	1,231	0	0	107,103	0
194.01 07951	OTHER NRCC	9,971	0	0	867,598	0
200.00	Cross Foot Adjustments		0	0	0	0
201.00	Negative Cost Centers	0	0	0	0	0
202.00	TOTAL (sum lines 118 through 201)	2,101,661	0	65,812	182,875,855	-65,812
						202.00

Cost Center Description		Total		
		26.00		
GENERAL SERVICE COST CENTERS				
1.00	00100 CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200 CAP REL COSTS-MVBL EQUIP			2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT			4.00
5.01	00540 NONPATIENT TELEPHONES			5.01
5.02	00590 PURCHASING			5.02
5.03	00570 ADMITTING			5.03
5.04	00580 CASHIERING/ACCOUNTS RECEIVABLE			5.04
5.05	00591 OTHER A&G			5.05
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
21.00	02100 I&R SERVICES-SALARY & FRINGES APPRV			21.00
22.00	02200 I&R SERVICES-OTHER PRGM COSTS APPRV			22.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS	36,810,038		30.00
31.00	03100 INTENSIVE CARE UNIT	7,630,885		31.00
32.00	03200 CORONARY CARE UNIT	0		32.00
32.01	02060 NEONATAL INTENSIVE CARE UNIT	1,349,072		32.01
40.00	04000 SUBPROVIDER - IPF	3,423,986		40.00
41.00	04100 SUBPROVIDER - IRF	0		41.00
42.00	04200 SUBPROVIDER	0		42.00
43.00	04300 NURSERY	733,638		43.00
44.00	04400 SKILLED NURSING FACILITY	0		44.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	15,575,534		50.00
51.00	05100 RECOVERY ROOM	1,512,726		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	3,486,429		52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	13,585,067		54.00
59.00	05900 CARDIAC CATHETERIZATION	3,139,419		59.00
60.00	06000 LABORATORY	7,215,666		60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	2,004,181		63.00
64.00	06400 INTRAVENOUS THERAPY	1,295,762		64.00
65.00	06500 RESPIRATORY THERAPY	4,872,484		65.00
66.00	06600 PHYSICAL THERAPY	1,054,685		66.00
69.00	06900 ELECTROCARDIOLOGY	1,322,943		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	319,392		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	10,140,212		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	7,845,300		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	12,363,715		73.00
74.00	07400 RENAL DIALYSIS	536,011		74.00
76.00	03950 ANCILLARY	0		76.00
76.01	03951 PARTIAL HOSPITALIZATION	1,418,797		76.01
OUTPATIENT SERVICE COST CENTERS				
91.00	09100 EMERGENCY	11,955,867		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART			92.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300 INTEREST EXPENSE			113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	149,591,809		118.00
NONREIMBURSABLE COST CENTERS				
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	97,574		190.00
190.01	19001 MARKETING	14,924		190.01
192.00	19200 PHYSICIANS' PRIVATE OFFICES	32,131,035		192.00
194.00	07950 SIRH	107,103		194.00
194.01	07951 OTHER NRCC	867,598		194.01
200.00	Cross Foot Adjustments	0		200.00
201.00	Negative Cost Centers	0		201.00
202.00	TOTAL (sum lines 118 through 201)	182,810,043		202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0009

Period:
From 08/01/2021
To 07/31/2022Worksheet B
Part II
Date/Time Prepared:
12/22/2022 2:33 pm

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00	2.00	2A	4.00
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	4.00
5.01 00540	NONPATIENT TELEPHONES	0	0	0	0	5.01
5.02 00590	PURCHASING	0	19,909	23,146	43,055	5.02
5.03 00570	ADMITTING	0	146,901	170,781	317,682	5.03
5.04 00580	CASHIERING/ACCOUNTS RECEIVABLE	0	217,238	252,553	469,791	5.04
5.05 00591	OTHER A&G	957,090	353,056	410,449	1,720,595	5.05
7.00 00700	OPERATION OF PLANT	0	587,846	683,407	1,271,253	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	0	0	0	8.00
9.00 00900	HOUSEKEEPING	0	0	0	0	9.00
10.00 01000	DIETARY	0	184,714	214,742	399,456	10.00
11.00 01100	CAFETERIA	0	0	0	0	11.00
13.00 01300	NURSING ADMINISTRATION	0	31,597	36,733	68,330	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	61,179	71,124	132,303	14.00
15.00 01500	PHARMACY	0	37,723	43,855	81,578	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	16.00
17.00 01700	SOCIAL SERVICE	0	0	0	0	17.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	767,453	892,210	1,659,663	30.00
31.00 03100	INTENSIVE CARE UNIT	0	74,267	86,340	160,607	31.00
32.00 03200	CORONARY CARE UNIT	0	0	0	0	32.00
32.01 02060	NEONATAL INTENSIVE CARE UNIT	0	0	0	0	32.01
40.00 04000	SUBPROVIDER - IPP	0	164,674	191,444	356,118	40.00
41.00 04100	SUBPROVIDER - IRF	0	0	0	0	41.00
42.00 04200	SUBPROVIDER	0	0	0	0	42.00
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	394,970	459,177	854,147	50.00
51.00 05100	RECOVERY ROOM	0	0	0	0	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	153,883	178,899	332,782	52.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	280,492	326,089	606,581	54.00
59.00 05900	CARDIAC CATHETERIZATION	0	64,483	74,966	139,449	59.00
60.00 06000	LABORATORY	0	115,344	134,095	249,439	60.00
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00
64.00 06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00 06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00 06600	PHYSICAL THERAPY	0	0	0	0	66.00
69.00 06900	ELECTROCARDIOLOGY	0	38,206	44,417	82,623	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	6,207	7,215	13,422	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	6,776	0	0	6,776	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
74.00 07400	RENAL DIALYSIS	0	0	0	0	74.00
76.00 03950	ANCILLARY	0	0	0	0	76.00
76.01 03951	PARTIAL HOSPITALIZATION	0	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS						
91.00 09100	EMERGENCY	0	204,331	237,548	441,879	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART				0	92.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	963,866	3,904,473	4,539,190	9,407,529	0
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	8,222	9,558	17,780	190.00
190.01 19001	MARKETING	0	0	0	0	190.01
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
194.00 07950	SIRH	0	0	0	0	194.00
194.01 07951	OTHER NRCC	0	22,851	26,566	49,417	194.01
200.00	Cross Foot Adjustments				0	200.00
201.00	Negative Cost Centers			0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	963,866	3,935,546	4,575,314	9,474,726	0

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0009

Period:
From 08/01/2021
To 07/31/2022Worksheet B
Part II
Date/Time Prepared:
12/22/2022 2:33 pm

Cost Center Description	NONPATIENT TELEPHONES	PURCHASING	ADMITTING	CASHIERING/ACC OUNTS RECEIVABLE	OTHER A&G	
					5.01	5.02
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBL EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01 00540	NONPATIENT TELEPHONES	0				5.01
5.02 00590	PURCHASING	0	43,055			5.02
5.03 00570	ADMITTING	0	463	318,145		5.03
5.04 00580	CASHIERING/ACCOUNTS RECEIVABLE	0	42	0	469,833	5.04
5.05 00591	OTHER A&G	0	4,448	0	0	1,725,043
7.00 00700	OPERATION OF PLANT	0	3,254	0	0	62,599
8.00 00800	LAUNDRY & LINEN SERVICE	0	95	0	0	8,557
9.00 00900	HOUSEKEEPING	0	1,425	0	0	25,190
10.00 01000	DIETARY	0	2,209	0	0	14,049
11.00 01100	CAFETERIA	0	0	0	0	16,087
13.00 01300	NURSING ADMINISTRATION	0	1,127	0	0	19,641
14.00 01400	CENTRAL SERVICES & SUPPLY	0	1,199	0	0	7,420
15.00 01500	PHARMACY	0	688	0	0	43,019
16.00 01600	MEDICAL RECORDS & LIBRARY	0	73	0	0	21,156
17.00 01700	SOCIAL SERVICE	0	54	0	0	19,344
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	614
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	3,546	31,516	46,558	265,463
31.00 03100	INTENSIVE CARE UNIT	0	2,095	5,381	7,950	59,779
32.00 03200	CORONARY CARE UNIT	0	0	0	0	0
32.01 02060	NEONATAL INTENSIVE CARE UNIT	0	0	1,032	1,524	11,788
40.00 04000	SUBPROVIDER - IPF	0	165	1,297	1,917	20,710
41.00 04100	SUBPROVIDER - IRF	0	0	0	0	0
42.00 04200	SUBPROVIDER	0	0	0	0	0
43.00 04300	NURSERY	0	363	1,106	1,633	5,128
44.00 04400	SKILLED NURSING FACILITY	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	2,757	40,765	60,220	126,044
51.00 05100	RECOVERY ROOM	0	163	3,439	5,081	13,325
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	562	1,415	2,091	25,300
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	1,997	49,119	72,406	116,715
59.00 05900	CARDIAC CATHETERIZATION	0	211	8,565	12,653	26,222
60.00 06000	LABORATORY	0	9,909	35,064	51,799	62,181
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	0	0	12,204	18,029	18,689
64.00 06400	INTRAVENOUS THERAPY	0	26	2,006	2,963	9,920
65.00 06500	RESPIRATORY THERAPY	0	744	20,620	30,462	44,439
66.00 06600	PHYSICAL THERAPY	0	7	1,682	2,485	9,608
69.00 06900	ELECTROCARDIOLOGY	0	157	7,279	10,753	11,040
70.00 07000	ELECTROENCEPHALOGRAPHY	0	75	1,992	2,943	2,763
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	25,017	36,958	87,535
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	8,601	12,706	72,312
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	30,354	44,841	73,076
74.00 07400	RENAL DIALYSIS	0	0	174	257	4,998
76.00 03950	ANCILLARY	0	0	0	0	0
76.01 03951	PARTIAL HOSPITALIZATION	0	100	1,418	2,094	12,863
OUTPATIENT SERVICE COST CENTERS						
91.00 09100	EMERGENCY	0	2,341	28,099	41,510	98,531
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	0	40,295	318,145	469,833	1,416,105
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	700
190.01 19001	MARKETING	0	0	0	0	139
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	2,751	0	0	299,558
194.00 07950	SIRH	0	0	0	0	999
194.01 07951	OTHER NRCC	0	9	0	0	7,542
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers	0	0	0	0	0
202.00	TOTAL (sum lines 118 through 201)	0	43,055	318,145	469,833	1,725,043

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0009

Period:
From 08/01/2021
To 07/31/2022Worksheet B
Part II
Date/Time Prepared:
12/22/2022 2:33 pm

Cost Center Description		OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
		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-MVBL EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540 NONPATIENT TELEPHONES						5.01
5.02	00590 PURCHASING						5.02
5.03	00570 ADMITTING						5.03
5.04	00580 CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05	00591 OTHER A&G						5.05
7.00	00700 OPERATION OF PLANT	1,337,106					7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	8,652				8.00
9.00	00900 HOUSEKEEPING	0	0	26,615			9.00
10.00	01000 DIETARY	94,608	0	92	510,414		10.00
11.00	01100 CAFETERIA	0	0	0	0		16,087
13.00	01300 NURSING ADMINISTRATION	16,183	0	26	0		268
14.00	01400 CENTRAL SERVICES & SUPPLY	31,335	0	330	0		0
15.00	01500 PHARMACY	19,321	0	92	0		804
16.00	01600 MEDICAL RECORDS & LIBRARY	0	0	53	0		349
17.00	01700 SOCIAL SERVICE	0	0	0	0		429
21.00	02100 I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0		0
22.00	02200 I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0		0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	393,075	3,759	12,948	338,670	4,906	30.00
31.00	03100 INTENSIVE CARE UNIT	38,038	1,311	3,583	63,032	483	31.00
32.00	03200 CORONARY CARE UNIT	0	0	0	0	0	32.00
32.01	02060 NEONATAL INTENSIVE CARE UNIT	0	0	0	0	214	32.01
40.00	04000 SUBPROVIDER - IPF	84,344	262	1,683	76,405	375	40.00
41.00	04100 SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200 SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300 NURSERY	0	87	7	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	202,298	2,010	1,142	0	1,582	50.00
51.00	05100 RECOVERY ROOM	0	0	0	0	268	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	78,817	262	1,683	7,763	456	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	143,664	262	1,313	0	1,448	54.00
59.00	05900 CARDIAC CATHETERIZATION	33,027	175	330	0	349	59.00
60.00	06000 LABORATORY	59,078	0	594	0	858	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0	0	188	64.00
65.00	06500 RESPIRATORY THERAPY	0	0	7	0	831	65.00
66.00	06600 PHYSICAL THERAPY	0	0	13	0	214	66.00
69.00	06900 ELECTROCARDIOLOGY	19,569	0	33	0	214	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	3,179	0	13	0	54	70.00
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
74.00	07400 RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950 ANCILLARY	0	0	0	0	0	76.00
76.01	03951 PARTIAL HOSPITALIZATION	0	0	20	0	349	76.01
OUTPATIENT SERVICE COST CENTERS							
91.00	09100 EMERGENCY	104,655	524	2,640	24,544	1,448	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300 INTEREST EXPENSE						113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	1,321,191	8,652	26,602	510,414	16,087	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	4,211	0	13	0	0	190.00
190.01	19001 MARKETING	0	0	0	0	0	190.01
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950 SIRH	0	0	0	0	0	194.00
194.01	07951 OTHER NRCC	11,704	0	0	0	0	0194.01
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	1,337,106	8,652	26,615	510,414	16,087	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0009

Period:
From 08/01/2021
To 07/31/2022Worksheet B
Part II
Date/Time Prepared:
12/22/2022 2:33 pm

Cost Center Description		NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		13.00	14.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS							
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBL EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540 NONPATIENT TELEPHONES						5.01
5.02	00590 PURCHASING						5.02
5.03	00570 ADMITTING						5.03
5.04	00580 CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05	00591 OTHER A&G						5.05
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	105,575					13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	172,587				14.00
15.00	01500 PHARMACY	7,595	0	153,097			15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	0	0	21,631		16.00
17.00	01700 SOCIAL SERVICE	0	0	173	0		17.00
21.00	02100 I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0		21.00
22.00	02200 I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0		22.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	46,333	0	70	17,140	3,970	30.00
31.00	03100 INTENSIVE CARE UNIT	4,557	159	49	1,221	837	31.00
32.00	03200 CORONARY CARE UNIT	0	0	0	0	0	32.00
32.01	02060 NEONATAL INTENSIVE CARE UNIT	2,025	0	0	181	148	32.01
40.00	04000 SUBPROVIDER - IPF	3,544	0	0	1,574	376	40.00
41.00	04100 SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200 SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300 NURSERY	1,013	48	1	1,424	80	43.00
44.00	04400 SKILLED NURSING FACILITY	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	14,937	2,039	6,734	0	1,709	50.00
51.00	05100 RECOVERY ROOM	2,532	22	0	16	166	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	4,304	165	9	75	383	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	5,233	24	0	1,491	54.00
59.00	05900 CARDIAC CATHETERIZATION	3,291	396	22	0	344	59.00
60.00	06000 LABORATORY	0	14,059	555	0	792	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	220	63.00
64.00	06400 INTRAVENOUS THERAPY	1,772	0	5,381	0	142	64.00
65.00	06500 RESPIRATORY THERAPY	0	2,863	20	0	535	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	0	116	66.00
69.00	06900 ELECTROCARDIOLOGY	0	0	446	0	145	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	35	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	131,692	0	0	1,113	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	15,819	0	0	861	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	139,571	0	1,357	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	0	59	74.00
76.00	03950 ANCILLARY	0	0	0	0	0	76.00
76.01	03951 PARTIAL HOSPITALIZATION	0	0	0	0	156	76.01
OUTPATIENT SERVICE COST CENTERS							
91.00	09100 EMERGENCY	13,672	92	42	0	1,312	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300 INTEREST EXPENSE						113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	105,575	172,587	153,097	21,631	16,354	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	11	190.00
190.01	19001 MARKETING	0	0	0	0	2	190.01
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	3,526	192.00
194.00	07950 SIRH	0	0	0	0	12	194.00
194.01	07951 OTHER NRCC	0	0	0	0	95	194.01
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	105,575	172,587	153,097	21,631	20,000	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0009

Period:
From 08/01/2021
To 07/31/2022Worksheet B
Part II
Date/Time Prepared:
12/22/2022 2:33 pm

Cost Center Description		INTERNS & RESIDENTS		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total
		SERVICES-SALAR Y & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV			
		21.00	22.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01 00540	NONPATIENT TELEPHONES					5.01
5.02 00590	PURCHASING					5.02
5.03 00570	ADMITTING					5.03
5.04 00580	CASHIERING/ACCOUNTS RECEIVABLE					5.04
5.05 00591	OTHER A&G					5.05
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
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRV			0		21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRV			621		22.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS			2,827,617	0	2,827,617
31.00 03100	INTENSIVE CARE UNIT			349,082	0	349,082
32.00 03200	CORONARY CARE UNIT			0	0	0
32.01 02060	NEONATAL INTENSIVE CARE UNIT			16,912	0	16,912
40.00 04000	SUBPROVIDER - IPP			548,770	0	548,770
41.00 04100	SUBPROVIDER - IRF			0	0	0
42.00 04200	SUBPROVIDER			0	0	0
43.00 04300	NURSERY			10,890	0	10,890
44.00 04400	SKILLED NURSING FACILITY			0	0	0
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM			1,316,384	0	1,316,384
51.00 05100	RECOVERY ROOM			25,012	0	25,012
52.00 05200	DELIVERY ROOM & LABOR ROOM			456,067	0	456,067
54.00 05400	RADIOLOGY-DIAGNOSTIC			1,000,253	0	1,000,253
59.00 05900	CARDIAC CATHETERIZATION			225,034	0	225,034
60.00 06000	LABORATORY			484,328	0	484,328
63.00 06300	BLOOD STORING, PROCESSING & TRANS.			49,142	0	49,142
64.00 06400	INTRAVENOUS THERAPY			22,398	0	22,398
65.00 06500	RESPIRATORY THERAPY			100,521	0	100,521
66.00 06600	PHYSICAL THERAPY			14,125	0	14,125
69.00 06900	ELECTROCARDIOLOGY			132,259	0	132,259
70.00 07000	ELECTROENCEPHALOGRAPHY			24,476	0	24,476
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT			289,091	0	289,091
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS			110,299	0	110,299
73.00 07300	DRUGS CHARGED TO PATIENTS			289,199	0	289,199
74.00 07400	RENAL DIALYSIS			5,488	0	5,488
76.00 03950	ANCILLARY			0	0	0
76.01 03951	PARTIAL HOSPITALIZATION			17,000	0	17,000
OUTPATIENT SERVICE COST CENTERS						
91.00 09100	EMERGENCY			761,289	0	761,289
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART			0	0	92.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)		0	0	9,075,636	0
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN			22,715	0	22,715
190.01 19001	MARKETING			141	0	141
192.00 19200	PHYSICIANS' PRIVATE OFFICES			305,835	0	305,835
194.00 07950	SIRH			1,011	0	1,011
194.01 07951	OTHER NRCC			68,767	0	68,767
200.00	Cross Foot Adjustments	0	621	621	0	621
201.00	Negative Cost Centers	0	0	0	0	0
202.00	TOTAL (sum lines 118 through 201)	0	621	9,474,726	0	9,474,726

Cost Center Description		CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	NONPATIENT TELEPHONES (# OF PHONE S)	PURCHASING (SUPPLIES)	
		BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
		1.00	2.00	4.00	5.01	5.02	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	390,605				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		390,605			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	75,542,378		4.00
5.01	00540	NONPATIENT TELEPHONES	0	0	257,070	1,014	5.01
5.02	00590	PURCHASING	1,976	1,976	549,952	15	4,454,269
5.03	00570	ADMITTING	14,580	14,580	2,130,509	14	47,919
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	21,561	21,561	0	46	4,359
5.05	00591	OTHER A&G	35,041	35,041	5,072,497	294	460,149
7.00	00700	OPERATION OF PLANT	58,344	58,344	891,701	28	336,686
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	87,700	2	9,850
9.00	00900	HOUSEKEEPING	0	0	1,663	0	147,472
10.00	01000	DIETARY	18,333	18,333	467,258	17	228,547
11.00	01100	CAFETERIA	0	0	562,787	0	0
13.00	01300	NURSING ADMINISTRATION	3,136	3,136	1,120,436	5	116,560
14.00	01400	CENTRAL SERVICES & SUPPLY	6,072	6,072	275,908	8	124,060
15.00	01500	PHARMACY	3,744	3,744	2,529,600	14	71,156
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	593,408	46	7,554
17.00	01700	SOCIAL SERVICE	0	0	1,202,000	17	5,563
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	51,640	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	76,170	76,170	12,759,961	82	366,834
31.00	03100	INTENSIVE CARE UNIT	7,371	7,371	524,295	27	216,757
32.00	03200	CORONARY CARE UNIT	0	0	0	0	32.00
32.01	02060	NEONATAL INTENSIVE CARE UNIT	0	0	762,082	10	0
40.00	04000	SUBPROVIDER - IPF	16,344	16,344	1,156,575	0	17,048
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	296,368	0	37,592
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	39,201	39,201	4,591,863	0	285,187
51.00	05100	RECOVERY ROOM	0	0	920,614	0	16,813
52.00	05200	DELIVERY ROOM & LABOR ROOM	15,273	15,273	1,542,673	70	58,110
54.00	05400	RADIOLOGY-DIAGNOSTIC	27,839	27,839	4,844,469	0	206,629
59.00	05900	CARDIAC CATHETERIZATION	6,400	6,400	1,664,258	14	21,847
60.00	06000	LABORATORY	11,448	11,448	2,037,092	14	1,025,070
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	426,333	50	0
64.00	06400	INTRAVENOUS THERAPY	0	0	635,249	21	2,656
65.00	06500	RESPIRATORY THERAPY	0	0	2,639,145	36	76,956
66.00	06600	PHYSICAL THERAPY	0	0	718,957	0	723
69.00	06900	ELECTROCARDIOLOGY	3,792	3,792	629,698	3	16,223
70.00	07000	ELECTROENCEPHALOGRAPHY	616	616	149,244	0	7,756
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	7	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	12	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	5	0
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
76.00	03950	ANCILLARY	0	0	0	0	76.00
76.01	03951	PARTIAL HOSPITALIZATION	0	0	963,160	0	10,387
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	20,280	20,280	4,182,325	51	242,239
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					91.00 92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	387,521	387,521	57,238,490	908	4,168,702
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	816	816	44,782	0	0
190.01	19001	MARKETING	0	0	0	0	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	18,259,106	0	284,646
194.00	07950	SIRH	0	0	0	106	0
194.01	07951	OTHER NRCC	2,268	2,268	0	0	921
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	3,935,546	4,575,314	7,550,832	884,278	633,399
203.00		Unit cost multiplier (Wkst. B, Part I)	10.075514	11.713404	0.099955	872.069034	0.142200
204.00		Cost to be allocated (per Wkst. B, Part II)			0	0	43,055

Cost Center Description		CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	NONPATIENT TELEPHONES (# OF PHONE S)	PURCHASING (SUPPLIES)	
		BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
		1.00	2.00				
205.00	Unit cost multiplier (Wkst. B, Part II)			0.000000	0.000000	0.009666	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 Center Description		ADMITTING (GROSS CHAR GES)	CASHIERING/ACC OUNTS RECEIVABLE (GROSS CHAR GES)	Reconciliation	OTHER A&G (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
		5.03	5.04	5A.05	5.05	7.00	
GENERAL SERVICE COST CENTERS							
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBL EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540 NONPATIENT TELEPHONES						5.01
5.02	00590 PURCHASING						5.02
5.03	00570 ADMITTING	723,056,727	723,056,727	-23,203,476	159,672,379	259,103	5.03
5.04	00580 CASHIERING/ACCOUNTS RECEIVABLE	0	0	0	5,794,020	7.00	5.04
5.05	00591 OTHER A&G	0	0	0	1,300,331	18,333	5.05
7.00	00700 OPERATION OF PLANT	0	0	0	792,058	0	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	0	0	2,331,534	0	8.00
9.00	00900 HOUSEKEEPING	0	0	0	1,488,982	0	9.00
10.00	01000 DIETARY	0	0	0	1,817,979	3,136	10.00
11.00	01100 CAFETERIA	0	0	0	686,821	6,072	11.00
13.00	01300 NURSING ADMINISTRATION	0	0	0	3,981,755	3,744	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	0	0	1,958,187	0	14.00
15.00	01500 PHARMACY	0	0	0	1,790,451	0	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700 SOCIAL SERVICE	0	0	0	0	0	17.00
21.00	02100 I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200 I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	56,802	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	71,628,224	71,628,224	0	24,570,853	76,170	30.00
31.00	03100 INTENSIVE CARE UNIT	12,230,132	12,230,132	0	5,533,069	7,371	31.00
32.00	03200 CORONARY CARE UNIT	0	0	0	0	0	32.00
32.01	02060 NEONATAL INTENSIVE CARE UNIT	2,344,871	2,344,871	0	1,091,090	0	32.01
40.00	04000 SUBPROVIDER - IPF	2,948,848	2,948,848	0	1,916,867	16,344	40.00
41.00	04100 SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200 SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300 NURSERY	2,513,037	2,513,037	0	474,647	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	92,646,731	92,646,731	0	11,666,396	39,201	50.00
51.00	05100 RECOVERY ROOM	7,816,698	7,816,698	0	1,233,324	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	3,216,894	3,216,894	0	2,341,763	15,273	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	111,632,479	111,632,479	0	10,802,981	27,839	54.00
59.00	05900 CARDIAC CATHETERIZATION	19,465,938	19,465,938	0	2,427,038	6,400	59.00
60.00	06000 LABORATORY	79,690,005	79,690,005	0	5,755,387	11,448	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	27,736,168	27,736,168	0	1,729,778	0	63.00
64.00	06400 INTRAVENOUS THERAPY	4,558,134	4,558,134	0	918,199	0	64.00
65.00	06500 RESPIRATORY THERAPY	46,864,731	46,864,731	0	4,113,168	0	65.00
66.00	06600 PHYSICAL THERAPY	3,822,478	3,822,478	0	889,274	0	66.00
69.00	06900 ELECTROCARDIOLOGY	16,543,457	16,543,457	0	1,021,798	3,792	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	4,527,503	4,527,503	0	255,767	616	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	56,857,820	56,857,820	0	8,102,127	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	19,547,439	19,547,439	0	6,693,113	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	68,986,624	68,986,624	0	6,763,763	0	73.00
74.00	07400 RENAL DIALYSIS	394,819	394,819	0	462,623	0	74.00
76.00	03950 ANCILLARY	0	0	0	0	0	76.00
76.01	03951 PARTIAL HOSPITALIZATION	3,221,884	3,221,884	0	1,190,548	0	76.01
OUTPATIENT SERVICE COST CENTERS							
91.00	09100 EMERGENCY	63,861,813	63,861,813	0	9,119,889	20,280	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300 INTEREST EXPENSE						113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	723,056,727	723,056,727	-23,203,476	131,072,382	256,019	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	64,812	816	190.00
190.01	19001 MARKETING	0	0	0	12,880	0	190.01
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	27,731,772	0	192.00
194.00	07950 SIRH	0	0	0	92,439	0	194.00
194.01	07951 OTHER NRCC	0	0	0	698,094	2,268	194.01
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	3,347,076	4,337,160	-23,203,476	6,636,001	202.00	
203.00	Unit cost multiplier (Wkst. B, Part I)	0.004629	0.005998	0.145319	25.611440	203.00	
204.00	Cost to be allocated (per Wkst. B, Part II)	318,145	469,833	1,725,043	1,337,106	204.00	
205.00	Unit cost multiplier (Wkst. B, Part II)	0.000440	0.000650	0.010804	5.160519	205.00	

Cost Center Description		ADMITTING (GROSS CHAR GES)	CASHIERING/ACC OUNTS RECEIVABLE (GROSS CHAR GES)	Reconciliation	OTHER A&G (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)	5.03	5.04	5A.05	5.05	7.00	206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

Cost Center Description		LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (DIRECT NRS ING)	
		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-MVBL EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540 NONPATIENT TELEPHONES						5.01
5.02	00590 PURCHASING						5.02
5.03	00570 ADMITTING						5.03
5.04	00580 CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05	00591 OTHER A&G						5.05
7.00	00700 OPERATION OF PLANT						7.00
8.00	00800 LAUNDRY & LINEN SERVICE	786,753					8.00
9.00	00900 HOUSEKEEPING	0	4,033				9.00
10.00	01000 DIETARY	0	14	112,631			10.00
11.00	01100 CAFETERIA	0	0	0	600		11.00
13.00	01300 NURSING ADMINISTRATION	0	4	0	10		13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	50	0	0		14.00
15.00	01500 PHARMACY	0	14	0	30		15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	8	0	13		16.00
17.00	01700 SOCIAL SERVICE	0	0	0	16		17.00
21.00	02100 I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0		21.00
22.00	02200 I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0		22.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	341,721	1,962	74,733	183	183	30.00
31.00	03100 INTENSIVE CARE UNIT	119,205	543	13,909	18	18	31.00
32.00	03200 CORONARY CARE UNIT	0	0	0	0	0	32.00
32.01	02060 NEONATAL INTENSIVE CARE UNIT	0	0	0	8	8	32.01
40.00	04000 SUBPROVIDER - IPF	23,841	255	16,860	14	14	40.00
41.00	04100 SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200 SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300 NURSERY	7,947	1	0	0	4	43.00
44.00	04400 SKILLED NURSING FACILITY	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	182,781	173	0	59	59	50.00
51.00	05100 RECOVERY ROOM	0	0	0	10	10	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	23,841	255	1,713	17	17	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	23,841	199	0	54	0	54.00
59.00	05900 CARDIAC CATHETERIZATION	15,894	50	0	13	13	59.00
60.00	06000 LABORATORY	0	90	0	32	0	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0	7	7	64.00
65.00	06500 RESPIRATORY THERAPY	0	1	0	31	0	65.00
66.00	06600 PHYSICAL THERAPY	0	2	0	8	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0	5	0	8	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	2	0	2	0	70.00
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
74.00	07400 RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950 ANCILLARY	0	0	0	0	0	76.00
76.01	03951 PARTIAL HOSPITALIZATION	0	3	0	13	0	76.01
OUTPATIENT SERVICE COST CENTERS							
91.00	09100 EMERGENCY	47,682	400	5,416	54	54	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300 INTEREST EXPENSE						113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	786,753	4,031	112,631	600	417	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	2	0	0	0	190.00
190.01	19001 MARKETING	0	0	0	0	0	190.01
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950 SIRH	0	0	0	0	0	194.00
194.01	07951 OTHER NRCC	0	0	0	0	0	194.01
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	907,159	2,670,350	1,968,099	1,705,359	2,193,554	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	1.153042	662.124969	17.473866	2,842.265000	5,260.321343	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	8,652	26,615	510,414	16,087	105,575	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.010997	6.599306	4.531736	26.811667	253.177458	205.00

Cost Center Description		LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (DIRECT NRS ING)	
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)	8.00	9.00	10.00	11.00	13.00	206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

Cost Center Description		CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	Reconciliation	SOCIAL SERVICE (ACCUM. COST)	
		14.00	15.00	16.00	17A	17.00	
GENERAL SERVICE COST CENTERS							
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBL EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540 NONPATIENT TELEPHONES						5.01
5.02	00590 PURCHASING						5.02
5.03	00570 ADMITTING						5.03
5.04	00580 CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05	00591 OTHER A&G						5.05
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	9,818,289					14.00
15.00	01500 PHARMACY	0	4,868,446				15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	0	15,312			16.00
17.00	01700 SOCIAL SERVICE	0	5,502	0	-2,101,661	180,774,194	17.00
21.00	02100 I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200 I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	65,056	22.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	0	2,211	12,134	0	36,387,020	30.00
31.00	03100 INTENSIVE CARE UNIT	9,051	1,558	864	0	7,543,188	31.00
32.00	03200 CORONARY CARE UNIT	0	0	0	0	0	32.00
32.01	02060 NEONATAL INTENSIVE CARE UNIT	0	0	128	0	1,333,568	32.01
40.00	04000 SUBPROVIDER - IPF	0	1	1,114	0	3,384,636	40.00
41.00	04100 SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200 SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300 NURSERY	2,707	27	1,008	0	725,207	43.00
44.00	04400 SKILLED NURSING FACILITY	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	116,012	214,150	0	0	15,396,534	50.00
51.00	05100 RECOVERY ROOM	1,225	2	11	0	1,495,341	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	9,377	281	53	0	3,446,362	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	297,705	774	0	0	13,428,942	54.00
59.00	05900 CARDIAC CATHETERIZATION	22,537	684	0	0	3,103,340	59.00
60.00	06000 LABORATORY	799,835	17,650	0	0	7,132,741	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	1,981,148	63.00
64.00	06400 INTRAVENOUS THERAPY	0	171,110	0	0	1,280,871	64.00
65.00	06500 RESPIRATORY THERAPY	162,873	644	0	0	4,816,488	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	0	1,042,564	66.00
69.00	06900 ELECTROCARDIOLOGY	0	14,169	0	0	1,307,739	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	315,721	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	7,491,795	0	0	0	10,023,677	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	899,930	0	0	0	7,755,139	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	4,438,337	0	0	12,221,626	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	0	529,851	74.00
76.00	03950 ANCILLARY	0	0	0	0	0	76.00
76.01	03951 PARTIAL HOSPITALIZATION	0	0	0	0	1,402,492	76.01
OUTPATIENT SERVICE COST CENTERS							
91.00	09100 EMERGENCY	5,242	1,346	0	0	11,818,466	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300 INTEREST EXPENSE						113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	9,818,289	4,868,446	15,312	-2,101,661	147,937,717	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	96,453	190.00
190.01	19001 MARKETING	0	0	0	0	14,752	190.01
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	31,761,773	192.00
194.00	07950 SIRH	0	0	0	0	105,872	194.00
194.01	07951 OTHER NRCC	0	0	0	0	857,627	194.01
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	975,248	4,908,617	2,284,995		2,101,661	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0.099330	1.008251	149.229036		0.011626	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	172,587	153,097	21,631		20,000	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.017578	0.031447	1.412683		0.000111	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0009

Period:
From 08/01/2021
To 07/31/2022

Worksheet B-1

Date/Time Prepared:
12/22/2022 2:33 pm

Cost Center Description		CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	Reconciliation	SOCIAL SERVICE (ACCUM. COST)	
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)	14.00	15.00	16.00	17A	17.00	206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

Cost Center Description		INTERNS & RESIDENTS		
		SERVICES-SALAR Y & FRINGES APPRV (ASSIGNED TIME)	SERVICES-OTHER PRGM COSTS APPRV (ASSIGNED TIME)	
		21.00	22.00	
GENERAL SERVICE COST CENTERS				
1.00	00100 CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200 CAP REL COSTS-MVBL EQUIP			2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT			4.00
5.01	00540 NONPATIENT TELEPHONES			5.01
5.02	00590 PURCHASING			5.02
5.03	00570 ADMITTING			5.03
5.04	00580 CASHIERING/ACCOUNTS RECEIVABLE			5.04
5.05	00591 OTHER A&G			5.05
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
21.00	02100 I&R SERVICES-SALARY & FRINGES APPRV	100		21.00
22.00	02200 I&R SERVICES-OTHER PRGM COSTS APPRV		100	22.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS	100	100	30.00
31.00	03100 INTENSIVE CARE UNIT	0	0	31.00
32.00	03200 CORONARY CARE UNIT	0	0	32.00
32.01	02060 NEONATAL INTENSIVE CARE UNIT	0	0	32.01
40.00	04000 SUBPROVIDER - IPP	0	0	40.00
41.00	04100 SUBPROVIDER - IRF	0	0	41.00
42.00	04200 SUBPROVIDER	0	0	42.00
43.00	04300 NURSERY	0	0	43.00
44.00	04400 SKILLED NURSING FACILITY	0	0	44.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000 LABORATORY	0	0	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	63.00
64.00	06400 INTRAVENOUS THERAPY	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	70.00
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	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	74.00
76.00	03950 ANCILLARY	0	0	76.00
76.01	03951 PARTIAL HOSPITALIZATION	0	0	76.01
OUTPATIENT SERVICE COST CENTERS				
91.00	09100 EMERGENCY	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART			92.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300 INTEREST EXPENSE			113.00
118.00	118.00 SUBTOTALS (SUM OF LINES 1 through 117)	100	100	118.00
NONREIMBURSABLE COST CENTERS				
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
190.01	19001 MARKETING	0	0	190.01
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	0	192.00
194.00	07950 SIRH	0	0	194.00
194.01	07951 OTHER NRCC	0	0	194.01
200.00	Cross Foot Adjustments			200.00
201.00	Negative Cost Centers			201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	0	65,812	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0.000000	658.120000	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	0	621	204.00

Cost Center Description		INTERNS & RESIDENTS		
		SERVICES-SALAR Y & FRINGES APPRV (ASSIGNED TIME)	SERVICES-OTHER PRGM COSTS APPRV (ASSIGNED TIME)	
		21.00	22.00	
205.00	Unit cost multiplier (Wkst. B, Part II)	0.000000	6.210000	205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)			206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)			207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0009

Period:
From 08/01/2021
To 07/31/2022Worksheet C
Part I
Date/Time Prepared:
12/22/2022 2:33 pm

Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Title XVIII		Hospital	PPS
			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	36,810,038		36,810,038	175,441	36,985,479
31.00 03100	INTENSIVE CARE UNIT	7,630,885		7,630,885	0	7,630,885
32.00 03200	CORONARY CARE UNIT	0		0	0	0
32.01 02060	NEONATAL INTENSIVE CARE UNIT	1,349,072		1,349,072	0	1,349,072
40.00 04000	SUBPROVIDER - IPF	3,423,986		3,423,986	0	3,423,986
41.00 04100	SUBPROVIDER - IRF	0		0	0	0
42.00 04200	SUBPROVIDER	0		0	0	0
43.00 04300	NURSERY	733,638		733,638	0	733,638
44.00 04400	SKILLED NURSING FACILITY	0		0	0	0
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	15,575,534		15,575,534	0	15,575,534
51.00 05100	RECOVERY ROOM	1,512,726		1,512,726	0	1,512,726
52.00 05200	DELIVERY ROOM & LABOR ROOM	3,486,429		3,486,429	0	3,486,429
54.00 05400	RADIOLOGY-DIAGNOSTIC	13,585,067		13,585,067	0	13,585,067
59.00 05900	CARDIAC CATHETERIZATION	3,139,419		3,139,419	0	3,139,419
60.00 06000	LABORATORY	7,215,666		7,215,666	0	7,215,666
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	2,004,181		2,004,181	0	2,004,181
64.00 06400	INTRAVENOUS THERAPY	1,295,762		1,295,762	0	1,295,762
65.00 06500	RESPIRATORY THERAPY	4,872,484	0	4,872,484	0	4,872,484
66.00 06600	PHYSICAL THERAPY	1,054,685	0	1,054,685	0	1,054,685
69.00 06900	ELECTROCARDIOLOGY	1,322,943		1,322,943	0	1,322,943
70.00 07000	ELECTROENCEPHALOGRAPHY	319,392		319,392	0	319,392
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	10,140,212		10,140,212	0	10,140,212
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	7,845,300		7,845,300	0	7,845,300
73.00 07300	DRUGS CHARGED TO PATIENTS	12,363,715		12,363,715	0	12,363,715
74.00 07400	RENAL DIALYSIS	536,011		536,011	0	536,011
76.00 03950	ANCILLARY	0		0	0	0
76.01 03951	PARTIAL HOSPITALIZATION	1,418,797		1,418,797	0	1,418,797
OUTPATIENT SERVICE COST CENTERS						
91.00 09100	EMERGENCY	11,955,867		11,955,867	0	11,955,867
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART	3,012,351		3,012,351	0	3,012,351
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
200.00	Subtotal (see instructions)	152,604,160	0	152,604,160	175,441	152,779,601
201.00	Less Observation Beds	3,012,351		3,012,351		3,012,351
202.00	Total (see instructions)	149,591,809	0	149,591,809	175,441	149,767,250
						202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0009

Period:
From 08/01/2021
To 07/31/2022Worksheet C
Part I
Date/Time Prepared:
12/22/2022 2:33 pm

			Title XVIII		Hospital	PPS
Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio
		Inpatient	Outpatient	Total (col. 6 + col. 7)		
		6.00	7.00	8.00	9.00	10.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	58,042,333		58,042,333	
31.00	03100	INTENSIVE CARE UNIT	12,230,132		12,230,132	
32.00	03200	CORONARY CARE UNIT	0		0	
32.01	02060	NEONATAL INTENSIVE CARE UNIT	2,344,871		2,344,871	
40.00	04000	SUBPROVIDER - IPF	2,948,848		2,948,848	
41.00	04100	SUBPROVIDER - IRF	0		0	
42.00	04200	SUBPROVIDER	0		0	
43.00	04300	NURSERY	2,513,037		2,513,037	
44.00	04400	SKILLED NURSING FACILITY	0		0	
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	20,688,583	71,958,148	92,646,731	0.168117
51.00	05100	RECOVERY ROOM	1,452,253	6,364,445	7,816,698	0.193525
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,839,554	377,340	3,216,894	1.083787
54.00	05400	RADIOLOGY-DIAGNOSTIC	28,882,281	82,750,198	111,632,479	0.121695
59.00	05900	CARDIAC CATHETERIZATION	9,582,035	9,883,903	19,465,938	0.161278
60.00	06000	LABORATORY	44,822,149	34,867,856	79,690,005	0.090547
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	15,041,394	12,694,774	27,736,168	0.072259
64.00	06400	INTRAVENOUS THERAPY	1,705,681	2,852,453	4,558,134	0.284275
65.00	06500	RESPIRATORY THERAPY	33,779,492	13,085,239	46,864,731	0.103969
66.00	06600	PHYSICAL THERAPY	3,106,419	716,059	3,822,478	0.275917
69.00	06900	ELECTROCARDIOLOGY	6,831,461	9,711,996	16,543,457	0.079968
70.00	07000	ELECTROENCEPHALOGRAPHY	570,165	3,957,338	4,527,503	0.070545
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	28,867,767	27,990,053	56,857,820	0.178343
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,771,113	12,776,326	19,547,439	0.401347
73.00	07300	DRUGS CHARGED TO PATIENTS	40,351,391	28,635,233	68,986,624	0.179219
74.00	07400	RENAL DIALYSIS	375,168	19,651	394,819	1.357612
76.00	03950	ANCILLARY	0	0	0	0.000000
76.01	03951	PARTIAL HOSPITALIZATION	1,808	3,220,076	3,221,884	0.440363
OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	22,155,750	41,706,063	63,861,813	0.187215
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	4,313,733	9,272,158	13,585,891	0.221726
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				
200.00		Subtotal (see instructions)	350,217,418	372,839,309	723,056,727	
201.00		Less Observation Beds				
202.00		Total (see instructions)	350,217,418	372,839,309	723,056,727	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0009

Period:
From 08/01/2021
To 07/31/2022Worksheet C
Part I
Date/Time Prepared:
12/22/2022 2:33 pm

Title XVIII

Hospital

PPS

Cost Center Description	PPS Inpatient Ratio	Title XVIII		
		Hospital	PPS	
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00 03000	ADULTS & PEDIATRICS			30.00
31.00 03100	INTENSIVE CARE UNIT			31.00
32.00 03200	CORONARY CARE UNIT			32.00
32.01 02060	NEONATAL INTENSIVE CARE UNIT			32.01
40.00 04000	SUBPROVIDER - IPF			40.00
41.00 04100	SUBPROVIDER - IRF			41.00
42.00 04200	SUBPROVIDER			42.00
43.00 04300	NURSERY			43.00
44.00 04400	SKILLED NURSING FACILITY			44.00
ANCILLARY SERVICE COST CENTERS				
50.00 05000	OPERATING ROOM	0.168117		50.00
51.00 05100	RECOVERY ROOM	0.193525		51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	1.083787		52.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0.121695		54.00
59.00 05900	CARDIAC CATHETERIZATION	0.161278		59.00
60.00 06000	LABORATORY	0.090547		60.00
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	0.072259		63.00
64.00 06400	INTRAVENOUS THERAPY	0.284275		64.00
65.00 06500	RESPIRATORY THERAPY	0.103969		65.00
66.00 06600	PHYSICAL THERAPY	0.275917		66.00
69.00 06900	ELECTROCARDIOLOGY	0.079968		69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0.070545		70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.178343		71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0.401347		72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0.179219		73.00
74.00 07400	RENAL DIALYSIS	1.357612		74.00
76.00 03950	ANCILLARY	0.000000		76.00
76.01 03951	PARTIAL HOSPITALIZATION	0.440363		76.01
OUTPATIENT SERVICE COST CENTERS				
91.00 09100	EMERGENCY	0.187215		91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART	0.221726		92.00
SPECIAL PURPOSE COST CENTERS				
113.00 11300	INTEREST EXPENSE			113.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0009

Period:
From 08/01/2021
To 07/31/2022Worksheet C
Part I
Date/Time Prepared:
12/22/2022 2:33 pm

Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Title XIX		Hospital	Cost
			Costs		Total Costs	RCE Disallowance
			Total Costs	RCE Disallowance		
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	36,810,038		36,810,038	175,441	36,985,479
31.00 03100	INTENSIVE CARE UNIT	7,630,885		7,630,885	0	7,630,885
32.00 03200	CORONARY CARE UNIT	0		0	0	0
32.01 02060	NEONATAL INTENSIVE CARE UNIT	1,349,072		1,349,072	0	1,349,072
40.00 04000	SUBPROVIDER - IPF	3,423,986		3,423,986	0	3,423,986
41.00 04100	SUBPROVIDER - IRF	0		0	0	0
42.00 04200	SUBPROVIDER	0		0	0	0
43.00 04300	NURSERY	733,638		733,638	0	733,638
44.00 04400	SKILLED NURSING FACILITY	0		0	0	0
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	15,575,534		15,575,534	0	15,575,534
51.00 05100	RECOVERY ROOM	1,512,726		1,512,726	0	1,512,726
52.00 05200	DELIVERY ROOM & LABOR ROOM	3,486,429		3,486,429	0	3,486,429
54.00 05400	RADIOLOGY-DIAGNOSTIC	13,585,067		13,585,067	0	13,585,067
59.00 05900	CARDIAC CATHETERIZATION	3,139,419		3,139,419	0	3,139,419
60.00 06000	LABORATORY	7,215,666		7,215,666	0	7,215,666
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	2,004,181		2,004,181	0	2,004,181
64.00 06400	INTRAVENOUS THERAPY	1,295,762		1,295,762	0	1,295,762
65.00 06500	RESPIRATORY THERAPY	4,872,484	0	4,872,484	0	4,872,484
66.00 06600	PHYSICAL THERAPY	1,054,685	0	1,054,685	0	1,054,685
69.00 06900	ELECTROCARDIOLOGY	1,322,943		1,322,943	0	1,322,943
70.00 07000	ELECTROENCEPHALOGRAPHY	319,392		319,392	0	319,392
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	10,140,212		10,140,212	0	10,140,212
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	7,845,300		7,845,300	0	7,845,300
73.00 07300	DRUGS CHARGED TO PATIENTS	12,363,715		12,363,715	0	12,363,715
74.00 07400	RENAL DIALYSIS	536,011		536,011	0	536,011
76.00 03950	ANCILLARY	0		0	0	0
76.01 03951	PARTIAL HOSPITALIZATION	1,418,797		1,418,797	0	1,418,797
OUTPATIENT SERVICE COST CENTERS						
91.00 09100	EMERGENCY	11,955,867		11,955,867	0	11,955,867
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART	3,012,351		3,012,351	0	3,012,351
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
200.00	Subtotal (see instructions)	152,604,160	0	152,604,160	175,441	152,779,601
201.00	Less Observation Beds	3,012,351		3,012,351		3,012,351
202.00	Total (see instructions)	149,591,809	0	149,591,809	175,441	149,767,250
						202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0009

Period:

From

08/01/2021

To

07/31/2022

Worksheet C

Part I

Date/Time Prepared:

12/22/2022 2:33 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	58,042,333		58,042,333	
31.00	03100	INTENSIVE CARE UNIT	12,230,132		12,230,132	
32.00	03200	CORONARY CARE UNIT	0		0	
32.01	02060	NEONATAL INTENSIVE CARE UNIT	2,344,871		2,344,871	
40.00	04000	SUBPROVIDER - IPF	2,948,848		2,948,848	
41.00	04100	SUBPROVIDER - IRF	0		0	
42.00	04200	SUBPROVIDER	0		0	
43.00	04300	NURSERY	2,513,037		2,513,037	
44.00	04400	SKILLED NURSING FACILITY	0		0	
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	20,688,583	71,958,148	92,646,731	0.168117
51.00	05100	RECOVERY ROOM	1,452,253	6,364,445	7,816,698	0.193525
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,839,554	377,340	3,216,894	1.083787
54.00	05400	RADIOLOGY-DIAGNOSTIC	28,882,281	82,750,198	111,632,479	0.121695
59.00	05900	CARDIAC CATHETERIZATION	9,582,035	9,883,903	19,465,938	0.161278
60.00	06000	LABORATORY	44,822,149	34,867,856	79,690,005	0.090547
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	15,041,394	12,694,774	27,736,168	0.072259
64.00	06400	INTRAVENOUS THERAPY	1,705,681	2,852,453	4,558,134	0.284275
65.00	06500	RESPIRATORY THERAPY	33,779,492	13,085,239	46,864,731	0.103969
66.00	06600	PHYSICAL THERAPY	3,106,419	716,059	3,822,478	0.275917
69.00	06900	ELECTROCARDIOLOGY	6,831,461	9,711,996	16,543,457	0.079968
70.00	07000	ELECTROENCEPHALOGRAPHY	570,165	3,957,338	4,527,503	0.070545
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	28,867,767	27,990,053	56,857,820	0.178343
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,771,113	12,776,326	19,547,439	0.401347
73.00	07300	DRUGS CHARGED TO PATIENTS	40,351,391	28,635,233	68,986,624	0.179219
74.00	07400	RENAL DIALYSIS	375,168	19,651	394,819	1.357612
76.00	03950	ANCILLARY	0	0	0	0.000000
76.01	03951	PARTIAL HOSPITALIZATION	1,808	3,220,076	3,221,884	0.440363
OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	22,155,750	41,706,063	63,861,813	0.187215
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	4,313,733	9,272,158	13,585,891	0.221726
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				
200.00		Subtotal (see instructions)	350,217,418	372,839,309	723,056,727	
201.00		Less Observation Beds				
202.00		Total (see instructions)	350,217,418	372,839,309	723,056,727	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0009

Period:
From 08/01/2021
To 07/31/2022Worksheet C
Part I
Date/Time Prepared:
12/22/2022 2:33 pm

			Title XIX	Hospital	Cost
Cost Center Description		PPS Inpatient Ratio			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
31.00	03100 INTENSIVE CARE UNIT				31.00
32.00	03200 CORONARY CARE UNIT				32.00
32.01	02060 NEONATAL INTENSIVE CARE UNIT				32.01
40.00	04000 SUBPROVIDER - IPF				40.00
41.00	04100 SUBPROVIDER - IRF				41.00
42.00	04200 SUBPROVIDER				42.00
43.00	04300 NURSERY				43.00
44.00	04400 SKILLED NURSING FACILITY				44.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.168117			50.00
51.00	05100 RECOVERY ROOM	0.193525			51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1.083787			52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.121695			54.00
59.00	05900 CARDIAC CATHETERIZATION	0.161278			59.00
60.00	06000 LABORATORY	0.090547			60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.072259			63.00
64.00	06400 INTRAVENOUS THERAPY	0.284275			64.00
65.00	06500 RESPIRATORY THERAPY	0.103969			65.00
66.00	06600 PHYSICAL THERAPY	0.275917			66.00
69.00	06900 ELECTROCARDIOLOGY	0.079968			69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.070545			70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.178343			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.401347			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.179219			73.00
74.00	07400 RENAL DIALYSIS	1.357612			74.00
76.00	03950 ANCILLARY	0.000000			76.00
76.01	03951 PARTIAL HOSPITALIZATION	0.440363			76.01
OUTPATIENT SERVICE COST CENTERS					
91.00	09100 EMERGENCY	0.187215			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.221726			92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300 INTEREST EXPENSE				113.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 15-0009

Period:
From 08/01/2021
To 07/31/2022Worksheet D
Part I
Date/Time Prepared:
12/22/2022 2:33 pm

Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Title XVIII		Hospital Per Diem (col. 3 / col. 4)	PPS
			Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)		
		1.00	2.00	3.00	4.00	5.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	2,827,617	0	2,827,617	31,800	88.92
31.00	INTENSIVE CARE UNIT	349,082		349,082	6,911	50.51
32.00	CORONARY CARE UNIT	0		0	0	0.00
32.01	NEONATAL INTENSIVE CARE UNIT	16,912		16,912	898	18.83
40.00	SUBPROVIDER - IPF	548,770	0	548,770	1,850	296.63
41.00	SUBPROVIDER - IRF	0	0	0	0	0.00
42.00	SUBPROVIDER	0	0	0	0	0.00
43.00	NURSERY	10,890		10,890	2,047	5.32
44.00	SKILLED NURSING FACILITY	0		0	0	0.00
200.00	Total (lines 30 through 199)	3,753,271		3,753,271	43,506	200.00
Cost Center Description		Inpatient Program Capital Cost (col. 5 x col. 6)				
			6.00	7.00		
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	9,524	846,874			30.00
31.00	INTENSIVE CARE UNIT	1,022	51,621			31.00
32.00	CORONARY CARE UNIT	0	0			32.00
32.01	NEONATAL INTENSIVE CARE UNIT	0	0			32.01
40.00	SUBPROVIDER - IPF	866	256,882			40.00
41.00	SUBPROVIDER - IRF	0	0			41.00
42.00	SUBPROVIDER	0	0			42.00
43.00	NURSERY	0	0			43.00
44.00	SKILLED NURSING FACILITY	0	0			44.00
200.00	Total (lines 30 through 199)	11,412	1,155,377			200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 15-0009

Period:
From 08/01/2021
To 07/31/2022Worksheet D
Part II
Date/Time Prepared:
12/22/2022 2:33 pm

Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Title XVIII		Hospital	Capital Costs (column 3 x column 4)	PPS
		Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges		
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	1,316,384	92,646,731	0.014209	6,187,278	87,915 50.00
51.00 05100	RECOVERY ROOM	25,012	7,816,698	0.003200	416,477	1,333 51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	456,067	3,216,894	0.141772	1,270	180 52.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	1,000,253	111,632,479	0.008960	10,324,053	92,504 54.00
59.00 05900	CARDIAC CATHETERIZATION	225,034	19,465,938	0.011560	2,558,974	29,582 59.00
60.00 06000	LABORATORY	484,328	79,690,005	0.006078	13,798,609	83,868 60.00
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	49,142	27,736,168	0.001772	3,274,866	5,803 63.00
64.00 06400	INTRAVENOUS THERAPY	22,398	4,558,134	0.004914	225,916	1,110 64.00
65.00 06500	RESPIRATORY THERAPY	100,521	46,864,731	0.002145	11,478,768	24,622 65.00
66.00 06600	PHYSICAL THERAPY	14,125	3,822,478	0.003695	1,223,501	4,521 66.00
69.00 06900	ELECTROCARDIOLOGY	132,259	16,543,457	0.007995	2,598,083	20,772 69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	24,476	4,527,503	0.005406	207,322	1,121 70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	289,091	56,857,820	0.005084	8,881,554	45,154 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	110,299	19,547,439	0.005643	2,857,523	16,125 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	289,199	68,986,624	0.004192	11,220,368	47,036 73.00
74.00 07400	RENAL DIALYSIS	5,488	394,819	0.013900	116,401	1,618 74.00
76.00 03950	ANCILLARY	0	0	0.000000	0	0 76.00
76.01 03951	PARTIAL HOSPITALIZATION	17,000	3,221,884	0.005276	410	2 76.01
OUTPATIENT SERVICE COST CENTERS						
91.00 09100	EMERGENCY	761,289	63,861,813	0.011921	6,498,242	77,466 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART	230,300	13,585,891	0.016951	1,012,772	17,167 92.00
200.00	Total (lines 50 through 199)	5,552,665	644,977,506		82,882,387	557,899 200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0009

Period:
From 08/01/2021
To 07/31/2022Worksheet D
Part III
Date/Time Prepared:
12/22/2022 2:33 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	
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
32.00 03200 CORONARY CARE UNIT	0	0	0	0	0	32.00
32.01 02060 NEONATAL INTENSIVE CARE UNIT	0	0	0	0	0	32.01
40.00 04000 SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00 04100 SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00 04200 SUBPROVIDER	0	0	0	0	0	42.00
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
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS	0	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
31.00 03100 INTENSIVE CARE UNIT	0					
32.00 03200 CORONARY CARE UNIT	0					
32.01 02060 NEONATAL INTENSIVE CARE UNIT	0					
40.00 04000 SUBPROVIDER - IPF	0					
41.00 04100 SUBPROVIDER - IRF	0					
42.00 04200 SUBPROVIDER	0					
43.00 04300 NURSERY	0					
44.00 04400 SKILLED NURSING FACILITY	0					
200.00 Total (lines 30 through 199)	0					
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS	0	Inpatient Program Pass-Through Cost (col. 7 x col. 8)				
31.00 03100 INTENSIVE CARE UNIT	0					
32.00 03200 CORONARY CARE UNIT	0					
32.01 02060 NEONATAL INTENSIVE CARE UNIT	0					
40.00 04000 SUBPROVIDER - IPF	0					
41.00 04100 SUBPROVIDER - IRF	0					
42.00 04200 SUBPROVIDER	0					
43.00 04300 NURSERY	0					
44.00 04400 SKILLED NURSING FACILITY	0					
200.00 Total (lines 30 through 199)	0					

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 15-0009

Period:
From 08/01/2021
To 07/31/2022Worksheet D
Part IV
Date/Time Prepared:
12/22/2022 2:33 pm

Cost Center Description	Title XVIII		Hospital		Allied Health
	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	
	1.00	2A	2.00	3A	3.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM	0	0	0	0	0 50.00
51.00 05100 RECOVERY ROOM	0	0	0	0	0 51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0 52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0 54.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	0	0 59.00
60.00 06000 LABORATORY	0	0	0	0	0 60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0 63.00
64.00 06400 INTRAVENOUS THERAPY	0	0	0	0	0 64.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	0	0 65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	0	0 66.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	0	0 69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0 70.00
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
74.00 07400 RENAL DIALYSIS	0	0	0	0	0 74.00
76.00 03950 ANCILLARY	0	0	0	0	0 76.00
76.01 03951 PARTIAL HOSPITALIZATION	0	0	0	0	0 76.01
OUTPATIENT SERVICE COST CENTERS					
91.00 09100 EMERGENCY	0	0	0	0	0 91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0 92.00
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: 15-0009

Period:
From 08/01/2021
To 07/31/2022Worksheet D
Part IV
Date/Time Prepared:
12/22/2022 2:33 pm

Cost Center Description	All Other Medical Education Cost	Title XVIII		Hospital	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	PPS
		Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)		
	4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	0	0	92,646,731	0.000000
51.00 05100	RECOVERY ROOM	0	0	0	7,816,698	0.000000
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	0	3,216,894	0.000000
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	0	0	111,632,479	0.000000
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	19,465,938	0.000000
60.00 06000	LABORATORY	0	0	0	79,690,005	0.000000
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	27,736,168	0.000000
64.00 06400	INTRAVENOUS THERAPY	0	0	0	4,558,134	0.000000
65.00 06500	RESPIRATORY THERAPY	0	0	0	46,864,731	0.000000
66.00 06600	PHYSICAL THERAPY	0	0	0	3,822,478	0.000000
69.00 06900	ELECTROCARDIOLOGY	0	0	0	16,543,457	0.000000
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	4,527,503	0.000000
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	56,857,820	0.000000
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	19,547,439	0.000000
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	68,986,624	0.000000
74.00 07400	RENAL DIALYSIS	0	0	0	394,819	0.000000
76.00 03950	ANCILLARY	0	0	0	0	0.000000
76.01 03951	PARTIAL HOSPITALIZATION	0	0	0	3,221,884	0.000000
OUTPATIENT SERVICE COST CENTERS						
91.00 09100	EMERGENCY	0	0	0	63,861,813	0.000000
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	13,585,891	0.000000
200.00	Total (lines 50 through 199)	0	0	0	644,977,506	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 15-0009

Period:
From 08/01/2021
To 07/31/2022Worksheet D
Part IV
Date/Time Prepared:
12/22/2022 2:33 pm

Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Title XVIII		Hospital	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PPS
		Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges		
	9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0.000000	6,187,278	0	16,190,886	0 50.00
51.00 05100	RECOVERY ROOM	0.000000	416,477	0	1,238,498	0 51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0.000000	1,270	0	205	0 52.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0.000000	10,324,053	0	19,028,849	0 54.00
59.00 05900	CARDIAC CATHETERIZATION	0.000000	2,558,974	0	3,639,305	0 59.00
60.00 06000	LABORATORY	0.000000	13,798,609	0	4,198,120	0 60.00
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	3,274,866	0	1,069,792	0 63.00
64.00 06400	INTRAVENOUS THERAPY	0.000000	225,916	0	916,061	0 64.00
65.00 06500	RESPIRATORY THERAPY	0.000000	11,478,768	0	2,943,275	0 65.00
66.00 06600	PHYSICAL THERAPY	0.000000	1,223,501	0	171,155	0 66.00
69.00 06900	ELECTROCARDIOLOGY	0.000000	2,598,083	0	3,050,526	0 69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0.000000	207,322	0	661,949	0 70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	8,881,554	0	6,317,718	0 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	2,857,523	0	4,828,167	0 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0.000000	11,220,368	0	9,551,186	0 73.00
74.00 07400	RENAL DIALYSIS	0.000000	116,401	0	4,143	0 74.00
76.00 03950	ANCILLARY	0.000000	0	0	0	0 76.00
76.01 03951	PARTIAL HOSPITALIZATION	0.000000	410	0	181,507	0 76.01
OUTPATIENT SERVICE COST CENTERS						
91.00 09100	EMERGENCY	0.000000	6,498,242	0	5,657,561	0 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	1,012,772	0	1,566,586	0 92.00
200.00	Total (lines 50 through 199)		82,882,387	0	81,215,489	0 200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-0009

Period:
From 08/01/2021
To 07/31/2022Worksheet D
Part V
Date/Time Prepared:
12/22/2022 2:33 pm

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Title XVIII		Hospital		PPS Services (see inst.)
		PPS Reimbursed Services (see inst.)	Charges	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
		1.00	2.00	3.00	4.00	5.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0.168117	16,190,886	0	0	2,721,963
51.00 05100	RECOVERY ROOM	0.193525	1,238,498	0	0	239,680
52.00 05200	DELIVERY ROOM & LABOR ROOM	1.083787	205	0	0	222
54.00 05400	RADIOLOGY-DIAGNOSTIC	0.121695	19,028,849	0	0	2,315,716
59.00 05900	CARDIAC CATHETERIZATION	0.161278	3,639,305	0	0	586,940
60.00 06000	LABORATORY	0.090547	4,198,120	1,737	0	380,127
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	0.072259	1,069,792	0	0	77,302
64.00 06400	INTRAVENOUS THERAPY	0.284275	916,061	0	0	260,413
65.00 06500	RESPIRATORY THERAPY	0.103969	2,943,275	0	0	306,009
66.00 06600	PHYSICAL THERAPY	0.275917	171,155	0	0	47,225
69.00 06900	ELECTROCARDIOLOGY	0.079968	3,050,526	0	0	243,944
70.00 07000	ELECTROENCEPHALOGRAPHY	0.070545	661,949	0	0	46,697
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.178343	6,317,718	0	0	1,126,721
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0.401347	4,828,167	0	0	1,937,770
73.00 07300	DRUGS CHARGED TO PATIENTS	0.179219	9,551,186	37,271	1,711,754	73.00
74.00 07400	RENAL DIALYSIS	1.357612	4,143	0	0	5,625
76.00 03950	ANCILLARY	0.000000	0	0	0	0
76.01 03951	PARTIAL HOSPITALIZATION	0.440363	181,507	0	0	79,929
OUTPATIENT SERVICE COST CENTERS						
91.00 09100	EMERGENCY	0.187215	5,657,561	0	0	1,059,180
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART	0.221726	1,566,586	0	0	347,353
200.00	Subtotal (see instructions)		81,215,489	1,737	37,271	13,494,570
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00	Net Charges (line 200 - line 201)		81,215,489	1,737	37,271	13,494,570
						202.00

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
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	59.00
60.00 06000 LABORATORY	157	0	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	63.00
64.00 06400 INTRAVENOUS THERAPY	0	0	64.00
65.00 06500 RESPIRATORY THERAPY	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	66.00
69.00 06900 ELECTROCARDIOLOGY	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	70.00
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	6,680	73.00
74.00 07400 RENAL DIALYSIS	0	0	74.00
76.00 03950 ANCILLARY	0	0	76.00
76.01 03951 PARTIAL HOSPITALIZATION	0	0	76.01
OUTPATIENT SERVICE COST CENTERS			
91.00 09100 EMERGENCY	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
200.00 Subtotal (see instructions)	157	6,680	200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00 Net Charges (line 200 - line 201)	157	6,680	202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 15-0009

Period:

From 08/01/2021

Worksheet D

To 07/31/2022

Part II

Date/Time Prepared:

12/22/2022 2:33 pm

Component CCN: 15-S009

Title XVIII

Subprovider -

IPF

PPS

Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	1,316,384	92,646,731	0.014209	982	14	50.00
51.00	05100 RECOVERY ROOM	25,012	7,816,698	0.003200	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	456,067	3,216,894	0.141772	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,000,253	111,632,479	0.008960	130,924	1,173	54.00
59.00	05900 CARDIAC CATHETERIZATION	225,034	19,465,938	0.011560	0	0	59.00
60.00	06000 LABORATORY	484,328	79,690,005	0.006078	586,142	3,563	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	49,142	27,736,168	0.001772	63,149	112	63.00
64.00	06400 INTRAVENOUS THERAPY	22,398	4,558,134	0.004914	24	0	64.00
65.00	06500 RESPIRATORY THERAPY	100,521	46,864,731	0.002145	70,823	152	65.00
66.00	06600 PHYSICAL THERAPY	14,125	3,822,478	0.003695	38,207	141	66.00
69.00	06900 ELECTROCARDIOLOGY	132,259	16,543,457	0.007995	2,865	23	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	24,476	4,527,503	0.005406	1,225	7	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	289,091	56,857,820	0.005084	33,861	172	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	110,299	19,547,439	0.005643	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	289,199	68,986,624	0.004192	671,371	2,814	73.00
74.00	07400 RENAL DIALYSIS	5,488	394,819	0.013900	0	0	74.00
76.00	03950 ANCILLARY	0	0	0.000000	0	0	76.00
76.01	03951 PARTIAL HOSPITALIZATION	17,000	3,221,884	0.005276	0	0	76.01
OUTPATIENT SERVICE COST CENTERS							
91.00	09100 EMERGENCY	761,289	63,861,813	0.011921	168,165	2,005	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	13,585,891	0.000000	0	0	92.00
200.00	Total (lines 50 through 199)	5,322,365	644,977,506		1,767,738	10,176	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTSProvider CCN: 15-0009
Component CCN: 15-S009Period:
From 08/01/2021
To 07/31/2022Worksheet D
Part IV
Date/Time Prepared:
12/22/2022 2:33 pm

Title XVIII

Subprovider -
IPF

PPS

Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM		0	0	0	0	0 50.00
51.00 05100 RECOVERY ROOM		0	0	0	0	0 51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM		0	0	0	0	0 52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC		0	0	0	0	0 54.00
59.00 05900 CARDIAC CATHETERIZATION		0	0	0	0	0 59.00
60.00 06000 LABORATORY		0	0	0	0	0 60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.		0	0	0	0	0 63.00
64.00 06400 INTRAVENOUS THERAPY		0	0	0	0	0 64.00
65.00 06500 RESPIRATORY THERAPY		0	0	0	0	0 65.00
66.00 06600 PHYSICAL THERAPY		0	0	0	0	0 66.00
69.00 06900 ELECTROCARDIOLOGY		0	0	0	0	0 69.00
70.00 07000 ELECTROENCEPHALOGRAPHY		0	0	0	0	0 70.00
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
74.00 07400 RENAL DIALYSIS		0	0	0	0	0 74.00
76.00 03950 ANCILLARY		0	0	0	0	0 76.00
76.01 03951 PARTIAL HOSPITALIZATION		0	0	0	0	0 76.01
OUTPATIENT SERVICE COST CENTERS						
91.00 09100 EMERGENCY		0	0	0	0	0 91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0	0	0	0	0 92.00
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: 15-0009 Component CCN: 15-S009	Period: From 08/01/2021 To 07/31/2022	Worksheet D Part IV Date/Time Prepared: 12/22/2022 2:33 pm	
			Title XVIII	Subprovider - IPF	PPS	
Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
	4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	0	92,646,731	0.000000	50.00
51.00 05100	RECOVERY ROOM	0	0	7,816,698	0.000000	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	3,216,894	0.000000	52.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	0	111,632,479	0.000000	54.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	19,465,938	0.000000	59.00
60.00 06000	LABORATORY	0	0	79,690,005	0.000000	60.00
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	0	0	27,736,168	0.000000	63.00
64.00 06400	INTRAVENOUS THERAPY	0	0	4,558,134	0.000000	64.00
65.00 06500	RESPIRATORY THERAPY	0	0	46,864,731	0.000000	65.00
66.00 06600	PHYSICAL THERAPY	0	0	3,822,478	0.000000	66.00
69.00 06900	ELECTROCARDIOLOGY	0	0	16,543,457	0.000000	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	4,527,503	0.000000	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	56,857,820	0.000000	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	19,547,439	0.000000	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	68,986,624	0.000000	73.00
74.00 07400	RENAL DIALYSIS	0	0	394,819	0.000000	74.00
76.00 03950	ANCILLARY	0	0	0	0.000000	76.00
76.01 03951	PARTIAL HOSPITALIZATION	0	0	3,221,884	0.000000	76.01
OUTPATIENT SERVICE COST CENTERS						
91.00 09100	EMERGENCY	0	0	63,861,813	0.000000	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	13,585,891	0.000000	92.00
200.00	Total (lines 50 through 199)	0	0	644,977,506		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTSProvider CCN: 15-0009
Component CCN: 15-S009Period:
From 08/01/2021
To 07/31/2022Worksheet D
Part IV
Date/Time Prepared:
12/22/2022 2:33 pm

Title XVIII

Subprovider -
IPF

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)	
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0.000000	982	0	0	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
54.00 05400	RADIOLOGY-DIAGNOSTIC	0.000000	130,924	0	0	0 54.00
59.00 05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0 59.00
60.00 06000	LABORATORY	0.000000	586,142	0	0	0 60.00
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	63,149	0	0	0 63.00
64.00 06400	INTRAVENOUS THERAPY	0.000000	24	0	0	0 64.00
65.00 06500	RESPIRATORY THERAPY	0.000000	70,823	0	0	0 65.00
66.00 06600	PHYSICAL THERAPY	0.000000	38,207	0	0	0 66.00
69.00 06900	ELECTROCARDIOLOGY	0.000000	2,865	0	0	0 69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0.000000	1,225	0	0	0 70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	33,861	0	0	0 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0.000000	671,371	0	0	0 73.00
74.00 07400	RENAL DIALYSIS	0.000000	0	0	0	0 74.00
76.00 03950	ANCILLARY	0.000000	0	0	0	0 76.00
76.01 03951	PARTIAL HOSPITALIZATION	0.000000	0	0	0	0 76.01
OUTPATIENT SERVICE COST CENTERS						
91.00 09100	EMERGENCY	0.000000	168,165	0	0	0 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0 92.00
200.00	Total (lines 50 through 199)		1,767,738	0	0	0 200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-0009

Period:
From 08/01/2021
To 07/31/2022Worksheet D
Part V
Date/Time Prepared:
12/22/2022 2:33 pm

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Title XIX		Hospital	Cost	
		PPS Reimbursed Services (see inst.)	Charges	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs PPS Services (see inst.)
		1.00	2.00	3.00	4.00	5.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0.168117	0	731,728	0	0 50.00
51.00 05100	RECOVERY ROOM	0.193525	0	92,105	0	0 51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	1.083787	0	12,873	0	0 52.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0.121695	0	1,292,176	0	0 54.00
59.00 05900	CARDIAC CATHETERIZATION	0.161278	0	79,708	0	0 59.00
60.00 06000	LABORATORY	0.090547	0	930,901	0	0 60.00
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	0.072259	0	143,519	0	0 63.00
64.00 06400	INTRAVENOUS THERAPY	0.284275	0	30,245	0	0 64.00
65.00 06500	RESPIRATORY THERAPY	0.103969	0	205,070	0	0 65.00
66.00 06600	PHYSICAL THERAPY	0.275917	0	3,954	0	0 66.00
69.00 06900	ELECTROCARDIOLOGY	0.079968	0	59,612	0	0 69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0.070545	0	52,856	0	0 70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.178343	0	424,528	0	0 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0.401347	0	92,102	0	0 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0.179219	0	266,591	0	0 73.00
74.00 07400	RENAL DIALYSIS	1.357612	0	0	0	0 74.00
76.00 03950	ANCILLARY	0.000000	0	0	0	0 76.00
76.01 03951	PARTIAL HOSPITALIZATION	0.440363	0	35,946	0	0 76.01
OUTPATIENT SERVICE COST CENTERS						
91.00 09100	EMERGENCY	0.187215	0	1,372,838	0	0 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART	0.221726	0	203,355	0	0 92.00
200.00	Subtotal (see instructions)		0	6,030,107	0	0 200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	0 201.00
202.00	Net Charges (line 200 - line 201)		0	6,030,107	0	0 202.00

Cost Center Description	Costs		Title XIX	Hospital	Cost
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM	123,016	0			50.00
51.00 05100 RECOVERY ROOM	17,825	0			51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	13,952	0			52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	157,251	0			54.00
59.00 05900 CARDIAC CATHETERIZATION	12,855	0			59.00
60.00 06000 LABORATORY	84,290	0			60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	10,371	0			63.00
64.00 06400 INTRAVENOUS THERAPY	8,598	0			64.00
65.00 06500 RESPIRATORY THERAPY	21,321	0			65.00
66.00 06600 PHYSICAL THERAPY	1,091	0			66.00
69.00 06900 ELECTROCARDIOLOGY	4,767	0			69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	3,729	0			70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	75,712	0			71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	36,965	0			72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	47,778	0			73.00
74.00 07400 RENAL DIALYSIS	0	0			74.00
76.00 03950 ANCILLARY	0	0			76.00
76.01 03951 PARTIAL HOSPITALIZATION	15,829	0			76.01
OUTPATIENT SERVICE COST CENTERS					
91.00 09100 EMERGENCY	257,016	0			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	45,089	0			92.00
200.00 Subtotal (see instructions)	937,455	0			200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0				201.00
202.00 Net Charges (line 200 - line 201)	937,455	0			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 15-0009

Period:

From 08/01/2021

Worksheet D

Part II

Date/Time Prepared:

12/22/2022 2:33 pm

			Title XIX		Subprovider - IPF		PPS	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,316,384	92,646,731	0.014209	0	0	50.00
51.00	05100	RECOVERY ROOM	25,012	7,816,698	0.003200	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	456,067	3,216,894	0.141772	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,000,253	111,632,479	0.008960	12,210	109	54.00
59.00	05900	CARDIAC CATHETERIZATION	225,034	19,465,938	0.011560	0	0	59.00
60.00	06000	LABORATORY	484,328	79,690,005	0.006078	39,956	243	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	49,142	27,736,168	0.001772	2,724	5	63.00
64.00	06400	INTRAVENOUS THERAPY	22,398	4,558,134	0.004914	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	100,521	46,864,731	0.002145	12,017	26	65.00
66.00	06600	PHYSICAL THERAPY	14,125	3,822,478	0.003695	967	4	66.00
69.00	06900	ELECTROCARDIOLOGY	132,259	16,543,457	0.007995	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	24,476	4,527,503	0.005406	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	289,091	56,857,820	0.005084	2,854	15	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	110,299	19,547,439	0.005643	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	289,199	68,986,624	0.004192	106,738	447	73.00
74.00	07400	RENAL DIALYSIS	5,488	394,819	0.013900	0	0	74.00
76.00	03950	ANCILLARY	0	0	0.000000	0	0	76.00
76.01	03951	PARTIAL HOSPITALIZATION	17,000	3,221,884	0.005276	0	0	76.01
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	761,289	63,861,813	0.011921	17,180	205	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	13,585,891	0.000000	0	0	92.00
200.00		Total (lines 50 through 199)	5,322,365	644,977,506		194,646	1,054	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 15-0009

Period:
From 08/01/2021
To 07/31/2022Worksheet D
Part IV
Date/Time Prepared:
12/22/2022 2:33 pm

Title XIX

Subprovider -
IPF

PPS

Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	0	0	0	0 50.00
51.00 05100	RECOVERY ROOM	0	0	0	0	0 51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0 52.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0 54.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	0 59.00
60.00 06000	LABORATORY	0	0	0	0	0 60.00
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0 63.00
64.00 06400	INTRAVENOUS THERAPY	0	0	0	0	0 64.00
65.00 06500	RESPIRATORY THERAPY	0	0	0	0	0 65.00
66.00 06600	PHYSICAL THERAPY	0	0	0	0	0 66.00
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0	0 69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0 70.00
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
74.00 07400	RENAL DIALYSIS	0	0	0	0	0 74.00
76.00 03950	ANCILLARY	0	0	0	0	0 76.00
76.01 03951	PARTIAL HOSPITALIZATION	0	0	0	0	0 76.01
OUTPATIENT SERVICE COST CENTERS						
91.00 09100	EMERGENCY	0	0	0	0	0 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0 92.00
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: 15-0009 Component CCN: 15-S009	Period: From 08/01/2021 To 07/31/2022	Worksheet D Part IV Date/Time Prepared: 12/22/2022 2:33 pm	
			Title XIX	Subprovider - IPF	PPS	
Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
	4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	0	92,646,731	0.000000	50.00
51.00 05100	RECOVERY ROOM	0	0	7,816,698	0.000000	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	3,216,894	0.000000	52.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	0	111,632,479	0.000000	54.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	19,465,938	0.000000	59.00
60.00 06000	LABORATORY	0	0	79,690,005	0.000000	60.00
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	0	0	27,736,168	0.000000	63.00
64.00 06400	INTRAVENOUS THERAPY	0	0	4,558,134	0.000000	64.00
65.00 06500	RESPIRATORY THERAPY	0	0	46,864,731	0.000000	65.00
66.00 06600	PHYSICAL THERAPY	0	0	3,822,478	0.000000	66.00
69.00 06900	ELECTROCARDIOLOGY	0	0	16,543,457	0.000000	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	4,527,503	0.000000	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	56,857,820	0.000000	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	19,547,439	0.000000	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	68,986,624	0.000000	73.00
74.00 07400	RENAL DIALYSIS	0	0	394,819	0.000000	74.00
76.00 03950	ANCILLARY	0	0	0	0.000000	76.00
76.01 03951	PARTIAL HOSPITALIZATION	0	0	3,221,884	0.000000	76.01
OUTPATIENT SERVICE COST CENTERS						
91.00 09100	EMERGENCY	0	0	63,861,813	0.000000	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	13,585,891	0.000000	92.00
200.00	Total (lines 50 through 199)	0	0	644,977,506		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTSProvider CCN: 15-0009
Component CCN: 15-S009Period:
From 08/01/2021
To 07/31/2022Worksheet D
Part IV
Date/Time Prepared:
12/22/2022 2:33 pm

Title XIX

Subprovider -

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)	
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0.000000	0	0	0	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
54.00 05400	RADIOLOGY-DIAGNOSTIC	0.000000	12,210	0	0	0 54.00
59.00 05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0 59.00
60.00 06000	LABORATORY	0.000000	39,956	0	0	0 60.00
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	2,724	0	0	0 63.00
64.00 06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0 64.00
65.00 06500	RESPIRATORY THERAPY	0.000000	12,017	0	0	0 65.00
66.00 06600	PHYSICAL THERAPY	0.000000	967	0	0	0 66.00
69.00 06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0 69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0 70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	2,854	0	0	0 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0.000000	106,738	0	0	0 73.00
74.00 07400	RENAL DIALYSIS	0.000000	0	0	0	0 74.00
76.00 03950	ANCILLARY	0.000000	0	0	0	0 76.00
76.01 03951	PARTIAL HOSPITALIZATION	0.000000	0	0	0	0 76.01
OUTPATIENT SERVICE COST CENTERS						
91.00 09100	EMERGENCY	0.000000	17,180	0	0	0 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0 92.00
200.00	Total (lines 50 through 199)		194,646	0	0	0 200.00

PART I - ALL PROVIDER COMPONENTS**INPATIENT DAYS**

1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	31,800	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	31,800	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.	27,037	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	2,173	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	9,524	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00

SWING BED ADJUSTMENT

17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	36,985,479	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)	36,985,479	27.00

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	58,042,333	28.00
29.00	Private room charges (excluding swing-bed charges)	54,209,567	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	3,832,766	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.637216	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	2,005.01	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	1,763.81	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)	241.20	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	153.70	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	4,155,587	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	32,829,892	37.00

PART II - HOSPITAL AND SUBPROVIDERS ONLY**PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS**

38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,163.07	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	11,077,079	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)	11,077,079	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0009

Period:
From 08/01/2021
To 07/31/2022Worksheet D-1
Date/Time Prepared:
12/22/2022 2:33 pm

Title XVIII

Hospital

PPS

Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
1.00	2.00	3.00	4.00	5.00			
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	7,630,885	6,911	1,104.17	1,022	1,128,462	43.00
44.00	CORONARY CARE UNIT	0	0	0.00	0	0	44.00
44.01	NEONATAL INTENSIVE CARE UNIT	1,349,072	898	1,502.31	0	0	44.01
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)					12,436,007	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48) (see instructions)					24,641,548	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)					898,495	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from wkst. D, sum of Parts II and IV)					557,899	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					1,456,394	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					23,185,154	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)					2,590	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,163.07	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					3,012,351	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0009

Period:
From 08/01/2021
To 07/31/2022Worksheet D-1
Date/Time Prepared:
12/22/2022 2:33 pm

Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	PPS
						1.00
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00 Capital-related cost	2,827,617	36,985,479	0.076452	3,012,351	230,300	90.00
91.00 Nursing Program cost	0	36,985,479	0.000000	3,012,351	0	91.00
92.00 Allied health cost	0	36,985,479	0.000000	3,012,351	0	92.00
93.00 All other Medical Education	0	36,985,479	0.000000	3,012,351	0	93.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0009

Worksheet D-1

Component CCN: 15-S009

Period:

From 08/01/2021

To 07/31/2022

Date/Time Prepared:

12/22/2022 2:33 pm

PPS

Title XVIII
Subprovider -
IPF

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)	1,850	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,850	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)	1,850	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	866	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00

SWING BED ADJUSTMENT

17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	3,423,986	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)	3,423,986	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)	3,423,986	37.00

PART II - HOSPITAL AND SUBPROVIDERS ONLY**PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS**

38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,850.80	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,602,793	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	1,602,793	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0009

Worksheet D-1

Component CCN: 15-S009

Period:

From 08/01/2021

To 07/31/2022

Date/Time Prepared:

12/22/2022 2:33 pm

PPS

Title XVIII

Subprovider -

IPF

Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
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	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT	0	0	0.00	0	0	44.00
44.01	NEONATAL INTENSIVE CARE UNIT	0	0	0.00	0	0	44.01
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)					249,805	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48) (see instructions)					1,852,598	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)					256,882	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					10,176	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					267,058	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					1,585,540	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)					70.00	
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					71.00	
72.00	Program routine service cost (line 9 x line 71)					72.00	
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)					73.00	
74.00	Total Program general inpatient routine service costs (line 72 + line 73)					74.00	
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					75.00	
76.00	Per diem capital-related costs (line 75 ÷ line 2)					76.00	
77.00	Program capital-related costs (line 9 x line 76)					77.00	
78.00	Inpatient routine service cost (line 74 minus line 77)					78.00	
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)					79.00	
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					80.00	
81.00	Inpatient routine service cost per diem limitation					81.00	
82.00	Inpatient routine service cost limitation (line 9 x line 81)					82.00	
83.00	Reasonable inpatient routine service costs (see instructions)					83.00	
84.00	Program inpatient ancillary services (see instructions)					84.00	
85.00	Utilization review - physician compensation (see instructions)					85.00	
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)					86.00	
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0009

Worksheet D-1

Component CCN: 15-S009

Period:

From 08/01/2021

To 07/31/2022

Date/Time Prepared:

12/22/2022 2:33 pm

</div

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0009

Period:
From 08/01/2021
To 07/31/2022Worksheet D-1
Date/Time Prepared:
12/22/2022 2:33 pm

Title XIX

Hospital

Cost Center Description		Cost
	1.00	
PART I - ALL PROVIDER COMPONENTS		
INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	31,800 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	31,800 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)	29,210 4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0 5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0 6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0 7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0 8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	1,071 9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0 10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0 11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0 12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0 13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0 14.00
15.00	Total nursery days (title V or XIX only)	2,047 15.00
16.00	Nursery days (title V or XIX only)	153 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)	36,810,038 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)	36,810,038 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)	36,810,038 37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY		
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,157.55 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,239,736 39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0 40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	1,239,736 41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0009

Period:
From 08/01/2021
To 07/31/2022Worksheet D-1
Date/Time Prepared:
12/22/2022 2:33 pm

		Title XIX		Hospital	Cost	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
42.00	NURSERY (title V & XIX only)	733,638	2,047	358.40	153	54,835
	Intensive Care Type Inpatient Hospital Units					
43.00	INTENSIVE CARE UNIT	7,630,885	6,911	1,104.17	140	154,584
44.00	CORONARY CARE UNIT	0	0	0.00	0	0
44.01	NEONATAL INTENSIVE CARE UNIT	1,349,072	898	1,502.31	100	150,231
45.00	BURN INTENSIVE CARE UNIT					
46.00	SURGICAL INTENSIVE CARE UNIT					
47.00	OTHER SPECIAL CARE (SPECIFY)					
	Cost Center Description					1.00
48.00	Program inpatient ancillary service cost (wkst. D-3, col. 3, line 200)					1,308,081
49.00	Total Program inpatient costs (sum of lines 41 through 48) (see instructions)					2,907,467
	PASS THROUGH COST ADJUSTMENTS					
50.00	Pass through costs applicable to Program inpatient routine services (from wkst. D, sum of Parts I and III)					0
51.00	Pass through costs applicable to Program inpatient ancillary services (from wkst. D, sum of Parts II and IV)					0
52.00	Total Program excludable cost (sum of lines 50 and 51)					0
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0
	TARGET AMOUNT AND LIMIT COMPUTATION					
54.00	Program discharges					0
55.00	Target amount per discharge					54.00
56.00	Target amount (line 54 x line 55)					0
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0
58.00	Bonus payment (see instructions)					0
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00
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
62.00	Relief payment (see instructions)					61.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0
	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
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)					64.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH (see instructions)					0
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
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)					67.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0
	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)					68.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					70.00
72.00	Program routine service cost (line 9 x line 71)					71.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)					72.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)					73.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					74.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)					75.00
77.00	Program capital-related costs (line 9 x line 76)					76.00
78.00	Inpatient routine service cost (line 74 minus line 77)					77.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)					78.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					79.00
81.00	Inpatient routine service cost per diem limitation					80.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)					81.00
83.00	Reasonable inpatient routine service costs (see instructions)					82.00
84.00	Program inpatient ancillary services (see instructions)					83.00
85.00	Utilization review - physician compensation (see instructions)					84.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)					85.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST					
87.00	Total observation bed days (see instructions)					86.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					87.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					88.00
						2,998,055

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0009

Period:
From 08/01/2021
To 07/31/2022

Worksheet D-1

Date/Time Prepared:
12/22/2022 2:33 pm

Cost Center Description	Cost	Routine Cost (from line 21)	Title XIX		Hospital	Cost
			column 1 ÷ column 2	Total Observation Bed Cost (from line 89)		
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00 Capital-related cost	2,827,617	36,810,038	0.076816	2,998,055	230,299	90.00
91.00 Nursing Program cost	0	36,810,038	0.000000	2,998,055	0	91.00
92.00 Allied health cost	0	36,810,038	0.000000	2,998,055	0	92.00
93.00 All other Medical Education	0	36,810,038	0.000000	2,998,055	0	93.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0009

Period:
From 08/01/2021
To 07/31/2022Worksheet D-1
Date/Time Prepared:
12/22/2022 2:33 pm
PPSTitle XIX
Subprovider -
IPF

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)	1,850 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,850 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)	1,850 4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0 5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0 6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0 7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0 8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	64 9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0 10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0 11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0 12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0 13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0 14.00
15.00	Total nursery days (title V or XIX only)	2,047 15.00
16.00	Nursery days (title V or XIX only)	153 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)	3,423,986 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)	3,423,986 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)	3,423,986 37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY		
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,850.80 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	118,451 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)	118,451 41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0009

Worksheet D-1

Component CCN: 15-S009

Period:

From 08/01/2021

To 07/31/2022

Date/Time Prepared:

12/22/2022 2:33 pm

PPS

Title XIX

Subprovider -

IPF

Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
						1.00	
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	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT	0	0	0.00	0	0	44.00
44.01	NEONATAL INTENSIVE CARE UNIT	0	0	0.00	0	0	44.01
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)					29,671	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48) (see instructions)					148,122	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					1,054	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					1,054	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					147,068	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)					70.00	
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					71.00	
72.00	Program routine service cost (line 9 x line 71)					72.00	
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)					73.00	
74.00	Total Program general inpatient routine service costs (line 72 + line 73)					74.00	
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					75.00	
76.00	Per diem capital-related costs (line 75 ÷ line 2)					76.00	
77.00	Program capital-related costs (line 9 x line 76)					77.00	
78.00	Inpatient routine service cost (line 74 minus line 77)					78.00	
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)					79.00	
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					80.00	
81.00	Inpatient routine service cost per diem limitation					81.00	
82.00	Inpatient routine service cost limitation (line 9 x line 81)					82.00	
83.00	Reasonable inpatient routine service costs (see instructions)					83.00	
84.00	Program inpatient ancillary services (see instructions)					84.00	
85.00	Utilization review - physician compensation (see instructions)					85.00	
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)					86.00	
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0009

Worksheet D-1

Component CCN: 15-S009

Period:

From 08/01/2021

To 07/31/2022

Date/Time Prepared:

12/22/2022 2:33 pm

PPS

Title XIX

Subprovider -

IPF

Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00 Capital-related cost	0	3,423,986	0.000000	0	0	90.00
91.00 Nursing Program cost	0	3,423,986	0.000000	0	0	91.00
92.00 Allied health cost	0	3,423,986	0.000000	0	0	92.00
93.00 All other Medical Education	0	3,423,986	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-0009

Period:
From 08/01/2021
To 07/31/2022Worksheet D-3
Date/Time Prepared:
12/22/2022 2:33 pm

Title XVIII

Hospital

PPS

Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		17,478,619		30.00
31.00	03100 INTENSIVE CARE UNIT		3,452,698		31.00
32.00	03200 CORONARY CARE UNIT		0		32.00
32.01	02060 NEONATAL INTENSIVE CARE UNIT		0		32.01
40.00	04000 SUBPROVIDER - IPF		0		40.00
41.00	04100 SUBPROVIDER - IRF		0		41.00
42.00	04200 SUBPROVIDER		0		42.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.168117	6,187,278	1,040,187	50.00
51.00	05100 RECOVERY ROOM	0.193525	416,477	80,599	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1.083787	1,270	1,376	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.121695	10,324,053	1,256,386	54.00
59.00	05900 CARDIAC CATHETERIZATION	0.161278	2,558,974	412,706	59.00
60.00	06000 LABORATORY	0.090547	13,798,609	1,249,423	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.072259	3,274,866	236,639	63.00
64.00	06400 INTRAVENOUS THERAPY	0.284275	225,916	64,222	64.00
65.00	06500 RESPIRATORY THERAPY	0.103969	11,478,768	1,193,436	65.00
66.00	06600 PHYSICAL THERAPY	0.275917	1,223,501	337,585	66.00
69.00	06900 ELECTROCARDIOLOGY	0.079968	2,598,083	207,764	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.070545	207,322	14,626	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.178343	8,881,554	1,583,963	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.401347	2,857,523	1,146,858	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.179219	11,220,368	2,010,903	73.00
74.00	07400 RENAL DIALYSIS	1.357612	116,401	158,027	74.00
76.00	03950 ANCILLARY	0.000000	0	0	76.00
76.01	03951 PARTIAL HOSPITALIZATION	0.440363	410	181	76.01
OUTPATIENT SERVICE COST CENTERS					
91.00	09100 EMERGENCY	0.187215	6,498,242	1,216,568	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.221726	1,012,772	224,558	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		82,882,387	12,436,007	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)		82,882,387		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0009 Component CCN: 15-S009	Period: From 08/01/2021 To 07/31/2022	Worksheet D-3 Date/Time Prepared: 12/22/2022 2:33 pm
		Title XVIII	Subprovider - IPF	PPS
Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
	1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00 03000 ADULTS & PEDIATRICS				30.00
31.00 03100 INTENSIVE CARE UNIT				31.00
32.00 03200 CORONARY CARE UNIT				32.00
32.01 02060 NEONATAL INTENSIVE CARE UNIT				32.01
40.00 04000 SUBPROVIDER - IPF			1,390,269	40.00
41.00 04100 SUBPROVIDER - IRF				41.00
42.00 04200 SUBPROVIDER				42.00
43.00 04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0.168117	982	165	50.00
51.00 05100 RECOVERY ROOM	0.193525	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	1.083787	0	0	52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.121695	130,924	15,933	54.00
59.00 05900 CARDIAC CATHETERIZATION	0.161278	0	0	59.00
60.00 06000 LABORATORY	0.090547	586,142	53,073	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0.072259	63,149	4,563	63.00
64.00 06400 INTRAVENOUS THERAPY	0.284275	24	7	64.00
65.00 06500 RESPIRATORY THERAPY	0.103969	70,823	7,363	65.00
66.00 06600 PHYSICAL THERAPY	0.275917	38,207	10,542	66.00
69.00 06900 ELECTROCARDIOLOGY	0.079968	2,865	229	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0.070545	1,225	86	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.178343	33,861	6,039	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.401347	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.179219	671,371	120,322	73.00
74.00 07400 RENAL DIALYSIS	1.357612	0	0	74.00
76.00 03950 ANCILLARY	0.000000	0	0	76.00
76.01 03951 PARTIAL HOSPITALIZATION	0.440363	0	0	76.01
OUTPATIENT SERVICE COST CENTERS				
91.00 09100 EMERGENCY	0.187215	168,165	31,483	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0.221726	0	0	92.00
200.00 Total (sum of lines 50 through 94 and 96 through 98)			1,767,738	249,805
201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61)			0	201.00
202.00 Net charges (line 200 minus line 201)			1,767,738	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0009	Period: From 08/01/2021 To 07/31/2022	Worksheet D-3	
		Title XIX		Hospital	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS			2,030,457	30.00
31.00	03100 INTENSIVE CARE UNIT			203,979	31.00
32.00	03200 CORONARY CARE UNIT			0	32.00
32.01	02060 NEONATAL INTENSIVE CARE UNIT			213,588	32.01
40.00	04000 SUBPROVIDER - IPF			0	40.00
41.00	04100 SUBPROVIDER - IRF			0	41.00
42.00	04200 SUBPROVIDER			0	42.00
43.00	04300 NURSERY			172,250	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.168117	497,724	83,676	50.00
51.00	05100 RECOVERY ROOM	0.193525	44,829	8,676	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1.083787	97,864	106,064	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.121695	866,827	105,489	54.00
59.00	05900 CARDIAC CATHETERIZATION	0.161278	213,754	34,474	59.00
60.00	06000 LABORATORY	0.090547	1,811,429	164,019	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.072259	298,188	21,547	63.00
64.00	06400 INTRAVENOUS THERAPY	0.284275	45,306	12,879	64.00
65.00	06500 RESPIRATORY THERAPY	0.103969	769,206	79,974	65.00
66.00	06600 PHYSICAL THERAPY	0.275917	67,337	18,579	66.00
69.00	06900 ELECTROCARDIOLOGY	0.079968	154,389	12,346	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.070545	21,556	1,521	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.178343	1,031,558	183,971	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.401347	91,309	36,647	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.179219	1,167,582	209,253	73.00
74.00	07400 RENAL DIALYSIS	1.357612	15,081	20,474	74.00
76.00	03950 ANCILLARY	0.000000	0	0	76.00
76.01	03951 PARTIAL HOSPITALIZATION	0.440363	0	0	76.01
OUTPATIENT SERVICE COST CENTERS					
91.00	09100 EMERGENCY	0.187215	902,041	168,876	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.221726	178,672	39,616	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		8,274,652	1,308,081	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net charges (line 200 minus line 201)		8,274,652	202.00	

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0009 Component CCN: 15-S009	Period: From 08/01/2021 To 07/31/2022	Worksheet D-3 Date/Time Prepared: 12/22/2022 2:33 pm
		Title XIX	Subprovider - IPF	PPS
Cost Center Description		Ratio of Cost To 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
32.00 03200	CORONARY CARE UNIT			32.00
32.01 02060	NEONATAL INTENSIVE CARE UNIT			32.01
40.00 04000	SUBPROVIDER - IPF		96,669	40.00
41.00 04100	SUBPROVIDER - IRF			41.00
42.00 04200	SUBPROVIDER			42.00
43.00 04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS				
50.00 05000	OPERATING ROOM	0.168117	0	50.00
51.00 05100	RECOVERY ROOM	0.193525	0	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	1.083787	0	52.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0.121695	12,210	54.00
59.00 05900	CARDIAC CATHETERIZATION	0.161278	0	59.00
60.00 06000	LABORATORY	0.090547	39,956	60.00
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	0.072259	2,724	63.00
64.00 06400	INTRAVENOUS THERAPY	0.284275	0	64.00
65.00 06500	RESPIRATORY THERAPY	0.103969	12,017	65.00
66.00 06600	PHYSICAL THERAPY	0.275917	967	66.00
69.00 06900	ELECTROCARDIOLOGY	0.079968	0	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0.070545	0	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.178343	2,854	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0.401347	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0.179219	106,738	73.00
74.00 07400	RENAL DIALYSIS	1.357612	0	74.00
76.00 03950	ANCILLARY	0.000000	0	76.00
76.01 03951	PARTIAL HOSPITALIZATION	0.440363	0	76.01
OUTPATIENT SERVICE COST CENTERS				
91.00 09100	EMERGENCY	0.187215	17,180	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART	0.221726	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		194,646	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)		194,646	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 15-0009

Period:
From 08/01/2021
To 07/31/2022Worksheet E
Part A
Date/Time Prepared:
12/22/2022 2:33 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)		3,440,508	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		17,191,554	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)		630	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)		154,257	2.04
3.00	Managed Care Simulated Payments		15,126,563	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		145.47	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)		4.49	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)		0.86	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)		3.63	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.68	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)		0.68	12.00
13.00	Total allowable FTE count for the prior year.		0.71	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.		0.96	14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.78	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		0.78	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.005362	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.004920	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.004920	21.00
22.00	IME payment adjustment (see instructions)		55,438	22.00
22.01	IME payment adjustment - Managed Care (see instructions)		40,645	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)		-2.95	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)		55,438	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		40,645	29.01
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		7.05	30.00
31.00	Percentage of Medicaid patient days (see instructions)		29.38	31.00
32.00	Sum of lines 30 and 31		36.43	32.00
33.00	Allowable disproportionate share percentage (see instructions)		19.27	33.00
34.00	Disproportionate share adjustment (see instructions)		993,950	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 15-0009

Period:
From 08/01/2021
To 07/31/2022Worksheet E
Part A
Date/Time Prepared:
12/22/2022 2:33 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	0	35.00
35.01	Factor 3 (see instructions)	0.000000000	0.000000000	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	1,819,792	1,061,065	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	304,129	883,737	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	1,187,866		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)	23,024,203		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)	23,064,848	49.00	
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	1,702,504	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).	31,645	52.00	
53.00	Nursing and Allied Health Managed Care payment	0	53.00	
54.00	Special add-on payments for new technologies	154,462	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)	24,953,459	59.00	
60.00	Primary payer payments	80,845	60.00	
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	24,872,614	61.00	
62.00	Deductibles billed to program beneficiaries	2,410,012	62.00	
63.00	Coinsurance billed to program beneficiaries	91,092	63.00	
64.00	Allowable bad debts (see instructions)	186,165	64.00	
65.00	Adjusted reimbursable bad debts (see instructions)	121,007	65.00	
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	21,759	66.00	
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	22,492,517	67.00	
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)	0	68.00	
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)	0	69.00	
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	70.00	
70.50	Rural Community Hospital Demonstration Project (§410A Demonstration) adjustment (see instructions)	0	70.50	
70.87	Demonstration payment adjustment amount before sequestration	0	70.87	
70.88	SCH or MDH volume decrease adjustment (contractor use only)	0	70.88	
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)	0	70.89	
70.90	HSP bonus payment HVBP adjustment amount (see instructions)	0	70.90	
70.91	HSP bonus payment HRR adjustment amount (see instructions)	0	70.91	
70.92	Bundled Model 1 discount amount (see instructions)	0	70.92	
70.93	HVBP payment adjustment amount (see instructions)	-29,983	70.93	
70.94	HRR adjustment amount (see instructions)	-254,210	70.94	
70.95	Recovery of accelerated depreciation	0	70.95	

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 15-0009

Period:
From 08/01/2021
To 07/31/2022Worksheet E
Part A
Date/Time Prepared:
12/22/2022 2:33 pm

	Title XVIII	Hospital	PPS	
		FFY (yyyy)	Amount	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		204,520	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		22,003,804	71.00
71.01	Sequestration adjustment (see instructions)		92,416	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
71.03	Sequestration adjustment-PARHM pass-throughs		0	71.03
72.00	Interim payments		21,590,357	72.00
72.01	Interim payments-PARHM		0	72.01
73.00	Tentative settlement (for contractor use only)		0	73.00
73.01	Tentative settlement-PARHM (for contractor use only)		0	73.01
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		321,031	74.00
74.01	Balance due provider/program-PARHM (see instructions)		0	74.01
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		559,258	75.00
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)				
90.00	operating outlier amount from wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00
		Prior to 10/1	On/After 10/1	
		1.00	2.00	
HSP Bonus Payment Amount				
100.00	HSP bonus amount (see instructions)	0	0	100.00
HVBP Adjustment for HSP Bonus Payment				
101.00	HVBP adjustment factor (see instructions)	0.0000000000	0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)	0	0	102.00
HRR Adjustment for HSP Bonus Payment				
103.00	HRR adjustment factor (see instructions)	0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)	0	0	104.00
Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment				
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
Cost Reimbursement				
201.00	Medicare inpatient service costs (from wkst. D-1, Pt. II, line 49)			201.00
202.00	Medicare discharges (see instructions)			202.00
203.00	Case-mix adjustment factor (see instructions)			203.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)				
204.00	Medicare target amount			204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)			205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			206.00
Adjustment to Medicare Part A Inpatient Reimbursement				
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare Part A inpatient service costs (from wkst. E, Pt. A, line 59)			208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)			211.00
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

		Title XVIII		Hospital		PPS
	Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00
1.00	DRG amounts other than outlier payments	1.00				1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	3,440,508	3,440,508		3,440,508
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	17,191,554		17,191,554	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0
2.00	Outlier payments for discharges (see instructions)	2.00				2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	630	630		630
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	154,257		154,257	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0
4.00	Managed care simulated payments	3.00	15,126,563	2,580,904	12,545,659	15,126,563
Indirect Medical Education Adjustment						
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.004920	0.004920	0.004920	5.00
6.00	IME payment adjustment (see instructions)	22.00	55,438	9,245	46,193	55,438
6.01	IME payment adjustment for managed care (see instructions)	22.01	40,645	6,935	33,710	40,645
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA						
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	55,438	9,245	46,193	55,438
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	40,645	6,935	33,710	40,645
Disproportionate Share Adjustment						
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1927	0.1927	0.1927	10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	993,950	165,747	828,203	993,950
11.01	Uncompensated care payments	36.00	1,187,866	304,129	883,737	1,187,866
Additional payment for high percentage of ESRD beneficiary discharges						
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0
13.00	Subtotal (see instructions)	47.00	23,024,203	3,920,259	19,103,944	23,024,203
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	23,064,848	3,927,194	19,137,654	23,064,848
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	1,702,504	276,911	1,425,593	1,702,504
17.00	Special add-on payments for new technologies	54.00	154,462	40,753	113,709	154,462
17.01	Net organ acquisition cost	68.00	0	0	0	17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	18.00
19.00	SUBTOTAL			4,244,858	20,676,956	24,921,814
						19.00

		Title XVIII		Hospital		PPS
		Wkst. L, line	(Amt. from Wkst. L)			
		0	1.00	2.00	3.00	4.00
20.00	Capital DRG other than outlier	1.00	1,538,119	256,095	1,282,024	1,538,119 20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0 20.01
21.00	Capital DRG outlier payments	2.00	43,181	636	42,545	43,181 21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0 21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0022	0.0022	0.0022	22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	3,384	563	2,821	3,384 23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0766	0.0766	0.0766	24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	117,820	19,617	98,203	117,820 25.00
26.00	Total prospective capital payments (see instructions)	12.00	1,702,504	276,911	1,425,593	1,702,504 26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)			
		0	1.00	2.00	3.00	4.00
27.00						27.00
28.00	Low volume adjustment prior to October 1	70.96	0	0		0 28.00
29.00	Low volume adjustment on or after October 1	70.97	0		0	0 29.00
30.00	HVBP payment adjustment (see instructions)	70.93	-29,983	-29,983	0	-29,983 30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0 30.01
31.00	HRR adjustment (see instructions)	70.94	-254,210	-29,242	-224,968	-254,210 31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0 31.01
						(Amt. to Wkst. E, Pt. A)
		0	1.00	2.00	3.00	4.00
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	204,520	204,520 32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Y			100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 15-0009

Period:
From 08/01/2021
To 07/31/2022Worksheet E
Part B
Date/Time Prepared:
12/22/2022 2:33 pm

	Title XVIII	Hospital	PPS
			1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES			
1.00	Medical and other services (see instructions)	6,837	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	13,494,570	2.00
3.00	OPPS payments	12,185,476	3.00
4.00	outlier payment (see instructions)	7,003	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)	6,837	11.00
COMPUTATION OF LESSER OF COST OR CHARGES			
Reasonable charges			
12.00	Ancillary service charges	39,008	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)	39,008	14.00
Customary charges			
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	39,008	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	32,171	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)	6,837	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)	12,192,479	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT			
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	2,227,972	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)	9,971,344	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	16,163	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)	9,987,507	30.00
31.00	Primary payer payments	10,704	31.00
32.00	Subtotal (line 30 minus line 31)	9,976,803	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)	148,024	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	96,216	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	43,897	36.00
37.00	Subtotal (see instructions)	10,073,019	37.00
38.00	MSP-LCC reconciliation amount from PS&R	831	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	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)	10,072,188	40.00
40.01	Sequestration adjustment (see instructions)	42,303	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	10,181,366	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)	0	43.00
43.01	Balance due provider/program-PARHM (see instructions)	-151,481	43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	1	44.00
TO BE COMPLETED BY CONTRACTOR			
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

Health Financial Systems

CALCULATION OF REIMBURSEMENT SETTLEMENT

CLARK MEMORIAL HOSPITAL

In Lieu of Form CMS-2552-10

Provider CCN: 15-0009

Period:
From 08/01/2021
To 07/31/2022

Worksheet E
Part B
Date/Time Prepared:
12/22/2022 2:33 pm

Title XVIII

Hospital

PPS

1.00

MEDICARE PART B ANCILLARY COSTS

200.00 Part B Combined Billed Days

0200.00

		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			21,522,357	
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		10,132,366
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)				1.00
	Program to Provider				2.00
3.01	ADJUSTMENTS TO PROVIDER	04/13/2022	68,000	04/13/2022	49,000
3.02			0		3.01
3.03			0		3.02
3.04			0		3.03
3.05			0		3.04
	Provider to Program				3.05
3.50	ADJUSTMENTS TO PROGRAM		0		3.50
3.51			0		3.51
3.52			0		3.52
3.53			0		3.53
3.54			0		3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		68,000		49,000
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)		21,590,357		10,181,366
	TO BE COMPLETED BY CONTRACTOR				4.00
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		5.01
5.02			0		5.02
5.03			0		5.03
	Provider to Program				
5.50	TENTATIVE TO PROGRAM		0		5.50
5.51			0		5.51
5.52			0		5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)				6.00
6.01	SETTLEMENT TO PROVIDER		321,031		6.01
6.02	SETTLEMENT TO PROGRAM		0		6.02
7.00	Total Medicare program liability (see instructions)		21,911,388		10,029,885
				Contractor Number	NPR Date (Mo/Day/Yr)
8.00	Name of Contractor		0	1.00	2.00
					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-0009

Period:
From 08/01/2021
To 07/31/2022Worksheet E-1
Part I
Date/Time Prepared:
12/22/2022 2:33 pm

Title XVIII

Subprovider -
IPF

PPS

		Inpatient Part A		Part B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount
1.00	Total interim payments paid to provider				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		846,590 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)		846,590		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		225		0 6.02
7.00	Total Medicare program liability (see instructions)		846,365		0 7.00
8.00 Name of Contractor				Contractor Number	NPR Date (Mo/Day/Yr)
			0	1.00	2.00
					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

Provider CCN: 15-0009

Period:
From 08/01/2021
To 07/31/2022Worksheet E-1
Part II
Date/Time Prepared:
12/22/2022 2:33 pm

Title XVIII

Hospital

PPS

1.00

TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS**HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION**

1.00	Total hospital discharges as defined in AARA §4102 from wkst. S-3, Pt. I col. 15 line 14	1.00
2.00	Medicare days (wkst. S-3, Pt. I, col. 6, sum of lines 1, and 8 through 12, and plus for cost reporting periods beginning on or after 10/01/2013, line 32)	2.00
3.00	Medicare HMO days from wkst. S-3, Pt. I, col. 6. line 2	3.00
4.00	Total inpatient days (wkst. S-3, Pt. I, col. 8, sum of lines 1, and 8 through 12, and plus for cost reporting periods beginning on or after 10/01/2013, line 32)	4.00
5.00	Total hospital charges from wkst C, Pt. I, col. 8 line 200	5.00
6.00	Total hospital charity care charges from wkst. S-10, col. 3 line 20	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology wkst. S-2, Pt. I line 168	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	8.00
9.00	Sequestration adjustment amount (see instructions)	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	10.00

INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH

30.00	Initial/interim HIT payment adjustment (see instructions)	30.00
31.00	other Adjustment (specify)	31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 15-0009

Period:
From 08/01/2021
To 07/31/2022Worksheet E-3
Part II
Date/Time Prepared:
12/22/2022 2:33 pmTitle XVIII
Subprovider -
IPF

PPS

1.00

PART II - MEDICARE PART A SERVICES - IPF PPS

1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)	821,837	1.00
2.00	Net IPF PPS Outlier Payments	121,806	2.00
3.00	Net IPF PPS ECT Payments	0	3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)	0.00	4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00	4.01
5.00	New Teaching program adjustment. (see instructions)	0.00	5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instuctions)	0.00	6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instuctions)	0.00	7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)	0.00	8.00
9.00	Average Daily Census (see instructions)	5.068493	9.00
10.00	Teaching Adjustment Factor $\{(1 + (\text{line 8}/\text{line 9})) \text{ raised to the power of .5150} - 1\}$.	0.000000	10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).	0	11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)	943,643	12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)	0	13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)	0	14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)	0	15.00
16.00	Subtotal (see instructions)	943,643	16.00
17.00	Primary payer payments	0	17.00
18.00	Subtotal (line 16 less line 17).	943,643	18.00
19.00	Deductibles	88,088	19.00
20.00	Subtotal (line 18 minus line 19)	855,555	20.00
21.00	Coinsurance	7,049	21.00
22.00	Subtotal (line 20 minus line 21)	848,506	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	2,199	23.00
24.00	Adjusted reimbursable bad debts (see instructions)	1,429	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	25.00
26.00	Subtotal (sum of lines 22 and 24)	849,935	26.00
27.00	Direct graduate medical education payments (see instructions)	0	27.00
28.00	other pass through costs (see instructions)	0	28.00
29.00	outlier payments reconciliation	0	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	30.50
30.98	Recovery of accelerated depreciation.	0	30.98
30.99	Demonstration payment adjustment amount before sequestration	0	30.99
31.00	Total amount payable to the provider (see instructions)	849,935	31.00
31.01	Sequestration adjustment (see instructions)	3,570	31.01
31.02	Demonstration payment adjustment amount after sequestration	0	31.02
32.00	Interim payments	846,590	32.00
33.00	Tentative settlement (for contractor use only)	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)	-225	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	35.00

TO BE COMPLETED BY CONTRACTOR

50.00	Original outlier amount from Worksheet E-3, Part II, line 2	121,806	50.00
51.00	outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money	0.00	52.00
53.00	Time Value of Money (see instructions)	0	53.00

FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING BEFORE THE END OF THE COVID-19 PHE

99.00	Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020.	0.000000	99.00
99.01	Calculated Teaching Adjustment Factor for the current year. (see instructions)	0.000000	99.01

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 15-0009

Period:
From 08/01/2021
To 07/31/2022Worksheet E-3
Part VII
Date/Time Prepared:
12/22/2022 2:33 pm

	Title XIX	Hospital	Cost	
		Inpatient	Outpatient	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES				
COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services	2,907,467	1.00	
2.00	Medical and other services	937,455	2.00	
3.00	Organ acquisition (certified transplant centers only)	0	3.00	
4.00	Subtotal (sum of lines 1, 2 and 3)	2,907,467	4.00	
5.00	Inpatient primary payer payments	0	5.00	
6.00	Outpatient primary payer payments	0	6.00	
7.00	Subtotal (line 4 less sum of lines 5 and 6)	2,907,467	7.00	
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable Charges				
8.00	Routine service charges	2,620,274	8.00	
9.00	Ancillary service charges	8,274,652	9.00	
10.00	Organ acquisition charges, net of revenue	0	10.00	
11.00	Incentive from target amount computation	0	11.00	
12.00	Total reasonable charges (sum of lines 8 through 11)	10,894,926	12.00	
CUSTOMARY CHARGES				
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	13.00	
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	14.00	
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	15.00	
16.00	Total customary charges (see instructions)	10,894,926	16.00	
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	7,987,459	17.00	
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	18.00	
19.00	Interns and Residents (see instructions)	0	19.00	
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	20.00	
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	2,907,467	21.00	
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.				
22.00	Other than outlier payments	0	22.00	
23.00	Outlier payments	0	23.00	
24.00	Program capital payments	0	24.00	
25.00	Capital exception payments (see instructions)	0	25.00	
26.00	Routine and Ancillary service other pass through costs	0	26.00	
27.00	Subtotal (sum of lines 22 through 26)	0	27.00	
28.00	Customary charges (title V or XIX PPS covered services only)	0	28.00	
29.00	Titles V or XIX (sum of lines 21 and 27)	2,907,467	29.00	
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)	0	30.00	
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	2,907,467	31.00	
32.00	Deductibles	0	32.00	
33.00	Coinsurance	0	33.00	
34.00	Allowable bad debts (see instructions)	0	34.00	
35.00	Utilization review	0	35.00	
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	2,907,467	36.00	
37.00	NO SETTLEMENT ADJUSTMENT	1,153,551	37.00	
38.00	Subtotal (line 36 ± line 37)	4,061,018	38.00	
39.00	Direct graduate medical education payments (from Wkst. E-4)	0	39.00	
40.00	Total amount payable to the provider (sum of lines 38 and 39)	4,061,018	40.00	
41.00	Interim payments	4,061,018	41.00	
42.00	Balance due provider/program (line 40 minus line 41)	0	42.00	
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	43.00	

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 15-0009

Worksheet E-3

Part VII

Date/Time Prepared:

12/22/2022 2:33 pm

PPS

Component CCN: 15-S009

Period:

From 08/01/2021

To 07/31/2022

Title XIX

Subprovider -

IPF

Inpatient

Outpatient

1.00

2.00

PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES**COMPUTATION OF NET COST OF COVERED SERVICES**

1.00	Inpatient hospital/SNF/NF services	0	1.00
2.00	Medical and other services	0	2.00
3.00	Organ acquisition (certified transplant centers only)	0	3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	0	4.00
5.00	Inpatient primary payer payments	0	5.00
6.00	Outpatient primary payer payments	0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	0	7.00

COMPUTATION OF LESSER OF COST OR CHARGES

8.00	Routine service charges	96,669	8.00
9.00	Ancillary service charges	194,646	9.00
10.00	Organ acquisition charges, net of revenue	0	10.00
11.00	Incentive from target amount computation	0	11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	291,315	12.00

CUSTOMARY CHARGES

13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000
16.00	Total customary charges (see instructions)	291,315	0
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	291,315	0
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	18.00
19.00	Interns and Residents (see instructions)	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	0	21.00

PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.

22.00	Other than outlier payments	0	22.00
23.00	Outlier payments	0	23.00
24.00	Program capital payments	0	24.00
25.00	Capital exception payments (see instructions)	0	25.00
26.00	Routine and Ancillary service other pass through costs	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	0	29.00

COMPUTATION OF REIMBURSEMENT SETTLEMENT

30.00	Excess of reasonable cost (from line 18)	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	0	31.00
32.00	Deductibles	0	32.00
33.00	Coinsurance	0	33.00
34.00	Allowable bad debts (see instructions)	0	34.00
35.00	Utilization review	0	35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	0	36.00
37.00	NO SETTLEMENT ADJUSTMENT	50,596	37.00
38.00	Subtotal (line 36 ± line 37)	50,596	38.00
39.00	Direct graduate medical education payments (from wkst. E-4)	0	39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	50,596	40.00
41.00	Interim payments	50,596	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	43.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS

Provider CCN: 15-0009

Period:
From 08/01/2021
To 07/31/2022Worksheet E-4
Date/Time Prepared:
12/22/2022 2:33 pm

		Title XVIII	Hospital	PPS
			1.00	

COMPUTATION OF TOTAL DIRECT GME AMOUNT

1.00	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.	4.49	1.00
2.00	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)	0.00	2.00
3.00	Amount of reduction to Direct GME cap under section 422 of MMA	0.86	3.00
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)	0.00	3.01
4.00	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))	0.00	4.00
4.01	ACA Section 5503 increase to the Direct GME FTE Cap (see instructions for cost reporting periods straddling 7/1/2011)	0.00	4.01
4.02	ACA Section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)	0.00	4.02
5.00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus lines 4.01 and 4.02 plus applicable subscripts)	3.63	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)	0.68	6.00
7.00	Enter the lesser of line 5 or line 6	0.68	7.00

		Primary Care	Other	Total
		1.00	2.00	3.00
8.00	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year.	0.68	0.00	0.68 8.00
9.00	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6.	0.68	0.00	0.68 9.00
10.00	Weighted dental and podiatric resident FTE count for the current year		0.00	10.00
10.01	Unweighted dental and podiatric resident FTE count for the current year		0.00	10.01
11.00	Total weighted FTE count	0.68	0.00	11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	0.71	0.00	12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	0.96	0.00	13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	0.78	0.00	14.00
15.00	Adjustment for residents in initial years of new programs	0.00	0.00	15.00
15.01	Unweighted adjustment for residents in initial years of new programs	0.00	0.00	15.01
16.00	Adjustment for residents displaced by program or hospital closure	0.00	0.00	16.00
16.01	Unweighted adjustment for residents displaced by program or hospital closure	0.00	0.00	16.01
17.00	Adjusted rolling average FTE count	0.78	0.00	17.00
18.00	Per resident amount	112,900.93	112,900.93	18.00
19.00	Approved amount for resident costs	88,063	0	88,063 19.00

			1.00	
20.00	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 Sec. 413.79(c) (4)		0.00	20.00
21.00	Direct GME FTE unweighted resident count over cap (see instructions)		0.00	21.00
22.00	Allowable additional direct GME FTE Resident Count (see instructions)		0.00	22.00
23.00	Enter the locality adjustment national average per resident amount (see instructions)		0.00	23.00
24.00	Multiply line 22 time line 23		0	24.00
25.00	Total direct GME amount (sum of lines 19 and 24)		88,063	25.00

		Inpatient Part A	Managed Care Prior to 1/1	Managed Care On or after 1/1	Total
		1.00	2.00	2.01	3.00

COMPUTATION OF PROGRAM PATIENT LOAD

26.00	Inpatient Days (see instructions) (Title XIX - see S-2 Part IX, line 3.02, column 2)	11,412	3,879	6,167	26.00
27.00	Total Inpatient Days (see instructions)	38,923	38,923	38,923	27.00
28.00	Ratio of inpatient days to total inpatient days	0.293194	0.099658	0.158441	28.00
29.00	Program direct GME amount	25,820	8,776	13,953	48,549 29.00
29.01	Percent reduction for MA DGME		3.26	3.26	29.01
30.00	Reduction for direct GME payments for Medicare Advantage		286	455	741 30.00
31.00	Net Program direct GME amount				47,808 31.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS

Provider CCN: 15-0009

Period:
From 08/01/2021
To 07/31/2022Worksheet E-4
Date/Time Prepared:
12/22/2022 2:33 pm

		Title XVIII	Hospital	PPS		
				1.00		
DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING PROGRAM AND PARAMEDICAL EDUCATION COSTS)						
32.00	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)		0	32.00		
33.00	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)	394,819	33.00			
34.00	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)	0.000000	34.00			
35.00	Medicare outpatient ESRD charges (see instructions)	0	35.00			
36.00	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)	0	36.00			
APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY						
Part A Reasonable Cost						
37.00	Reasonable cost (see instructions)	26,494,146	37.00			
38.00	Organ acquisition costs (Wkst. D-4, Pt. III, col. 1, line 69)	0	38.00			
39.00	Cost of physicians' services in a teaching hospital (see instructions)	0	39.00			
40.00	Primary payer payments (see instructions)	80,845	40.00			
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)	26,413,301	41.00			
Part B Reasonable Cost						
42.00	Reasonable cost (see instructions)	13,501,407	42.00			
43.00	Primary payer payments (see instructions)	10,704	43.00			
44.00	Total Part B reasonable cost (line 42 minus line 43)	13,490,703	44.00			
45.00	Total reasonable cost (sum of lines 41 and 44)	39,904,004	45.00			
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)	0.661921	46.00			
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)	0.338079	47.00			
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B						
48.00	Total program GME payment (line 31)	47,808	48.00			
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)	31,645	49.00			
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)	16,163	50.00			
	Y/N	Primary Care	Other	Total		
	0	1.00	2.00	3.00		
E-4 Calculation - In accordance with the FY 2023 IPPS Final Rule.						
109.00	Enter in column 0, "Y" or "N" to calculate line 9 in accordance the Federal Fiscal Year 2023 Final Rule for cost reporting periods beginning prior to 10/1/2021. (see instructions)	N	0.00	0.00	0.00	109.00
122.00	override of line 22 for cost reporting periods beginning prior to 10/1/2021. (see instructions)		0.00			122.00

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

Provider CCN: 15-0009

Period:
From 08/01/2021
To 07/31/2022

Worksheet G
Date/Time Prepared:
12/22/2022 2:33 pm

	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund		
				1.00	2.00	3.00
CURRENT ASSETS						
1.00	Cash on hand in banks	361,061	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	21,876,050	0	0	0	4.00
5.00	Other receivable	-1,098,992	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	4,091,814	0	0	0	7.00
8.00	Prepaid expenses	2,450,009	0	0	0	8.00
9.00	Other current assets	0	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)	27,679,942	0	0	0	11.00
FIXED ASSETS						
12.00	Land	3,179,787	0	0	0	12.00
13.00	Land improvements	533,923	0	0	0	13.00
14.00	Accumulated depreciation	-326,551	0	0	0	14.00
15.00	Buildings	19,582,983	0	0	0	15.00
16.00	Accumulated depreciation	-4,053,043	0	0	0	16.00
17.00	Leasehold improvements	6,214,692	0	0	0	17.00
18.00	Accumulated depreciation	-992,994	0	0	0	18.00
19.00	Fixed equipment	8,926,449	0	0	0	19.00
20.00	Accumulated depreciation	-1,355,524	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	13,696,735	0	0	0	23.00
24.00	Accumulated depreciation	-7,609,172	0	0	0	24.00
25.00	Minor equipment depreciable	10,211,825	0	0	0	25.00
26.00	Accumulated depreciation	-7,767,547	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)	40,241,563	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	19,730,655	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	19,730,655	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	87,652,160	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	7,065,531	0	0	0	37.00
38.00	Salaries, wages, and fees payable	4,487,520	0	0	0	38.00
39.00	Payroll taxes payable	3,023,609	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	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	0	0	0	0	43.00
44.00	Other current liabilities	1,471,682	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	16,048,342	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	21,919,920	0	0	0	46.00
47.00	Notes payable	1,472,018	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	23,391,938	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	39,440,280	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	48,211,880	0	0	0	52.00
53.00	Specific purpose fund		0	0	0	53.00
54.00	Donor created - endowment fund balance - restricted			0	0	54.00
55.00	Donor created - endowment fund balance - unrestricted			0	0	55.00
56.00	Governing body created - endowment fund balance			0	0	56.00
57.00	Plant fund balance - invested in plant			0	0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion			0	0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	48,211,880	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	87,652,160	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 15-0009

Period:
From 08/01/2021
To 07/31/2022Worksheet G-1
Date/Time Prepared:
12/22/2022 2:33 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		69,482,190		0	1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-16,803,507		0	2.00
3.00	Total (sum of line 1 and line 2)		52,678,683		0	3.00
4.00	IMPUTED INCOME TAX	-4,466,755		0	0	4.00
5.00	ROUNDING	-48	0	0	0	5.00
6.00		0	0	0	0	6.00
7.00		0	0	0	0	7.00
8.00		0	0	0	0	8.00
9.00		0	0	0	0	9.00
10.00	Total additions (sum of line 4-9)		-4,466,803		0	10.00
11.00	Subtotal (line 3 plus line 10)		48,211,880		0	11.00
12.00	Deductions (debit adjustments) (specify)	0		0	0	12.00
13.00		0	0	0	0	13.00
14.00		0	0	0	0	14.00
15.00		0	0	0	0	15.00
16.00		0	0	0	0	16.00
17.00		0	0	0	0	17.00
18.00	Total deductions (sum of lines 12-17)	0		0	0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		48,211,880		0	19.00
		Endowment Fund	Plant Fund			
			6.00	7.00	8.00	
1.00	Fund balances at beginning of period	0		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		0	0	0	2.00
3.00	Total (sum of line 1 and line 2)	0		0	0	3.00
4.00	IMPUTED INCOME TAX		0	0	0	4.00
5.00	ROUNDING		0	0	0	5.00
6.00			0	0	0	6.00
7.00			0	0	0	7.00
8.00			0	0	0	8.00
9.00			0	0	0	9.00
10.00	Total additions (sum of line 4-9)	0		0	0	10.00
11.00	Subtotal (line 3 plus line 10)	0		0	0	11.00
12.00	Deductions (debit adjustments) (specify)		0	0	0	12.00
13.00			0	0	0	13.00
14.00			0	0	0	14.00
15.00			0	0	0	15.00
16.00			0	0	0	16.00
17.00			0	0	0	17.00
18.00	Total deductions (sum of lines 12-17)	0		0	0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0	0	19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 15-0009

Period:
From 08/01/2021
To 07/31/2022Worksheet G-2
Parts I & II
Date/Time Prepared:
12/22/2022 2:33 pm

Cost Center Description		Inpatient	Outpatient	Total
		1.00	2.00	3.00
PART I - PATIENT REVENUES				
General Inpatient Routine Services				
1.00	Hospital	58,042,333		58,042,333
2.00	SUBPROVIDER - IPF	2,948,848		2,948,848
3.00	SUBPROVIDER - IRF	0		0
4.00	SUBPROVIDER	0		0
5.00	Swing bed - SNF	0		0
6.00	Swing bed - NF	0		0
7.00	SKILLED NURSING FACILITY	0		0
8.00	NURSING FACILITY			7.00
9.00	OTHER LONG TERM CARE			8.00
10.00	Total general inpatient care services (sum of lines 1-9)	60,991,181		9.00
				10.00
Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	12,230,132		11.00
12.00	CORONARY CARE UNIT	0		12.00
12.01	NEONATAL INTENSIVE CARE UNIT	2,344,871		12.01
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)	14,575,003		16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	75,566,184		17.00
18.00	Ancillary services	245,668,712	321,861,086	18.00
19.00	Outpatient services	26,469,483	50,978,221	19.00
20.00	RURAL HEALTH CLINIC	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	21.00
22.00	HOME HEALTH AGENCY			22.00
23.00	AMBULANCE SERVICES			23.00
24.00	CMHC			24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)			25.00
26.00	HOSPICE			26.00
27.00	NURSERY	2,513,037	0	27.00
27.01	PROFESSIONAL FEE CHARGES	0	32,696,383	27.01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to wkst. G-3, line 1)	350,217,416	405,535,690	28.00
				755,753,106
PART II - OPERATING EXPENSES				
29.00	Operating expenses (per wkst. A, column 3, line 200)		199,944,763	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	IMPUTED INCOME TAX	4,466,755		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)		4,466,755	42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to wkst. G-3, line 4)		195,478,008	43.00

		1.00	
1.00	Total patient revenues (from wkst. G-2, Part I, column 3, line 28)	755,753,106	1.00
2.00	Less contractual allowances and discounts on patients' accounts	579,362,071	2.00
3.00	Net patient revenues (line 1 minus line 2)	176,391,035	3.00
4.00	Less total operating expenses (from wkst. G-2, Part II, line 43)	195,478,008	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-19,086,973	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	6,727	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	368,495	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	841	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	6,367	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	378,629	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISCELLANEOUS INCOME	1,522,407	24.00
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	2,283,466	25.00
26.00	Total (line 5 plus line 25)	-16,803,507	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-16,803,507	29.00

CALCULATION OF CAPITAL PAYMENT

Provider CCN: 15-0009

Period:
From 08/01/2021
To 07/31/2022Worksheet L
Parts I-III
Date/Time Prepared:
12/22/2022 2:33 pm

	Title XVIII	Hospital	PPS
		1.00	
PART I - FULLY PROSPECTIVE METHOD			
CAPITAL FEDERAL AMOUNT			
1.00	Capital DRG other than outlier	1,538,119	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	43,181	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)	101.78	3.00
4.00	Number of interns & residents (see instructions)	0.78	4.00
5.00	Indirect medical education percentage (see instructions)	0.22	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)	3,384	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (worksheet E, part A line 30) (see instructions)	7.05	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	29.38	8.00
9.00	Sum of lines 7 and 8	36.43	9.00
10.00	Allowable disproportionate share percentage (see instructions)	7.66	10.00
11.00	Disproportionate share adjustment (see instructions)	117,820	11.00
12.00	Total prospective capital payments (see instructions)	1,702,504	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